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the Wisconsin Medical Journal

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FOUNDATION PROGRESS

MEDICAL STUDENT LOANS . . . WHO NEEDS HELP?

The CES Foundation of the State Medical Society currently has about $70,000 on loan to medical students at the Universities of Wisconsin and Marquette. Many applications are still pending. A few facts from the June 1960 report of the Association of American Medical Colleges tells why.

FACT: Over 99% of all medical students work some or all of the time while in medical school. Deans recommend no more than 10 hours per week of outside work . . . yet 10% of medical students work 40 hours per week or more, the average student works 15 hours weekly.

FACT: If funds were available, the average medical student reports he would borrow at least $4,000 in additional funds during 4 years of education.

FACT: The median amount of loans received by medical students during four years of schooling is $2,555.

What are you doing to help the student loan fund of the CES Foundation?

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MEDICAL MEETINGS—POSTGRADUATE COURSES

Congress of Allergology

The IVth International Congress of Allergology will be held at the Hotel Commodore, New York City, October 15–20, 1961. Those concerned with allergic diseases and related fields of immunology will be interested. Registration fee for regular members will be $45, for wives $20. For further information contact: William B. Sherman, M.D., 60 East 58th Street, New York 22, New York.

EET Spring Congress

The Gill Memorial Eye, Ear and Throat Hospital will hold its 34th annual Spring Congress in Ophthalmology and Otolaryngology and Allied Specialties, April 3 through April 8, 1961. There will be 20 guest speakers and 50 lectures.

American College of Physicians

A postgraduate course on "Clinical Patho-Physiologic Conferences" will be held February 20–24 at the Oklahoma University Medical Center by the American College of Physicians.

For further details contact the ACP, 4200 Pine Street, Philadelphia 4, Pennsylvania.

Courses at University of Minnesota

Medical continuation courses to be presented at the center for Continuation Study, University of Minnesota, are as follows:

Jan. 26–28: Otolaryngology for Specialists

Feb. 6–8: Anesthesiology for Specialists

Feb. 13–18: Neurology for General Physicians and Internists

Feb. 27–Mar. 1: Pediatrics for General Physicians and Specialists

Mar. 13–15: Allergy for General Physicians and Specialists

Mar. 17–18: Trauma for General Physicians

Apr. 17–19: Internal Medicine for Internists

Apr. 20–22: Otolaryngology for General Physicians

May 11–12: Surgery for Surgeons

For further information concerning the above courses, write to the Director, Department of Continuation Medical Education, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14, Minnesota.

Mayo Clinical Reviews

Staff members of the Mayo Clinic and the Mayo Foundation for Medical Education and Research, Rochester, Minn., will present again this year a three-day program of lectures and discussions on problems of current interest in general medicine and surgery, April 10, 11 and 12.

The American Academy of General Practice and the College of General Practice of Canada have advised the Committee on Clinical Reviews that up to 21 hours of Category I credit may be obtained by members of the American Academy of General Practice or the College of General Practice of Canada attending.

There are no fees for this program.

WISCONSIN CALENDAR COMING EVENTS

1961

Jan. 19 & 26; Feb. 2 & 9: Current Views in Medical Practice, UW postgraduate course, University Hospitals, Madison.

Jan. 24: Meeting, Milwaukee Oto-Ophthalmic Society, Univ. Club, Milwaukee.

Jan. 24–26: Circuit teaching programs; Dodgeville on Tues., Fond du Lac on Wed., Sheboygan on Thurs.

Feb. 6 & 7: Postgraduate course: Recent Advances in Diagnosis and Treatment of Neurological Diseases, UW, Milwaukee.

Feb. 25–26: SMS Council Meeting, Madison.

Feb. 28: Meeting, Milwaukee Oto-Opthalmic Society, Univ. Club, Milwaukee.

Mar. 28: Meeting, Milwaukee Oto-Ophthalmic Society, Univ. Club, Milwaukee.

Apr. 13–15: Hematologic Disorders in Pediatrics, UW postgraduate course, Wisconsin Center Building, Madison.

Apr. 25: Meeting, Milwaukee Oto-Ophthalmic Society, Univ. Club, Milwaukee.

May 2–3–4: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 11–13: Pathology and Radiology of Chest Diseases, UW postgraduate course, Wisconsin Center Building, Madison.

May 23: Annual social meeting, Milwaukee Oto-Ophthalmic Society, Univ. Club, Milwaukee.

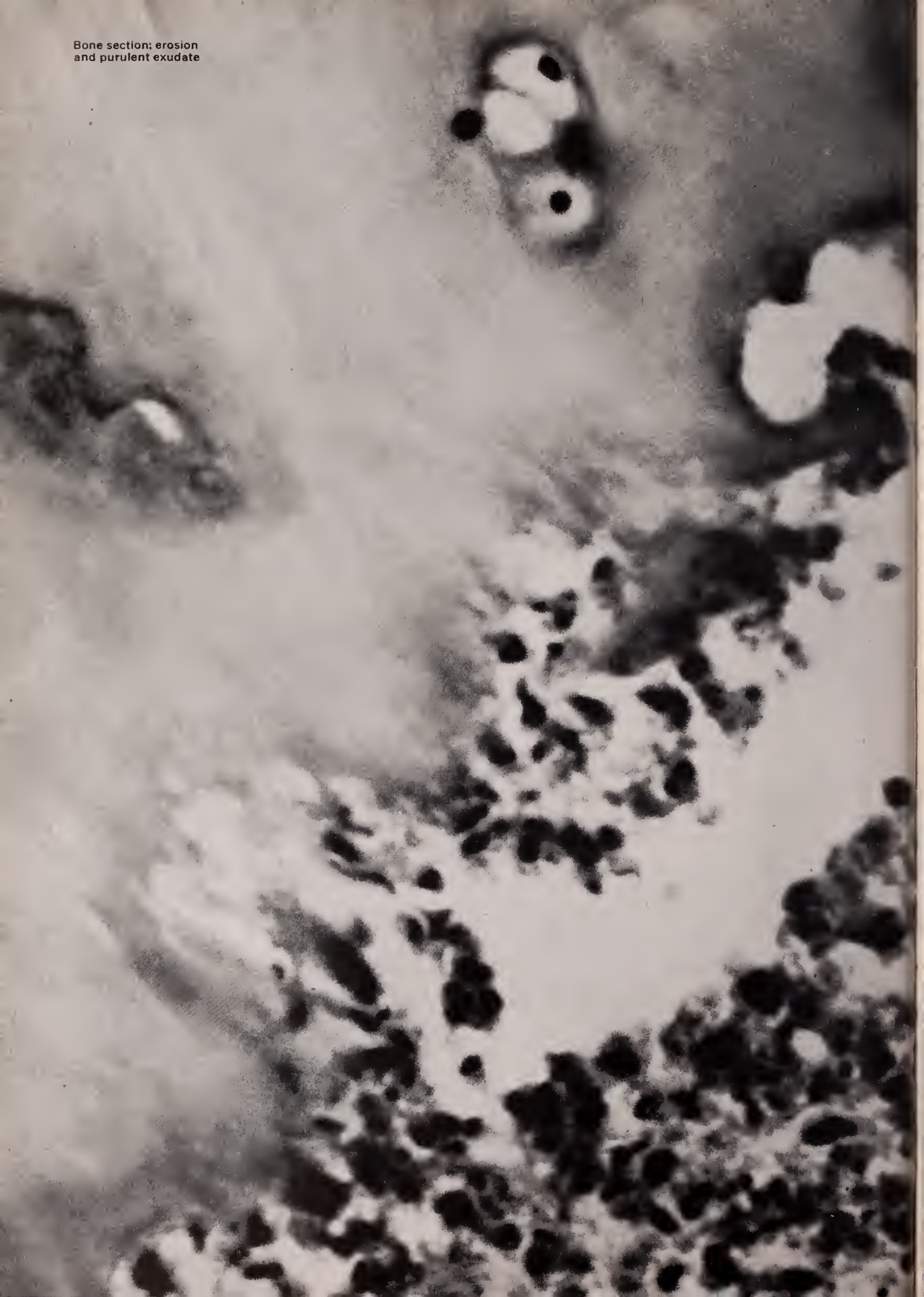
June 26–30: AMA Annual Meeting, New York, New York.

Nov. 28–Dec. 1: AMA Clinical Meeting, Denver, Colorado.

1962

June 11–15: AMA Annual Meeting, Chicago, Illinois.

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California.



Bone section: erosion and purulent exudate

MEDICAL MEETINGS

The number of physicians who can be accommodated is necessarily limited. Those wishing to attend should communicate with the Clinical Reviews Committee, Mayo Clinic, Rochester, Minnesota.

Medical Tour of Israel

A medical tour of Israel constituting a clinical post-graduate program will be offered by University of California Extension's department of continuing education in medicine in the spring, April 20–May 15.

Opportunities will be provided for physicians to observe the rapid development of modern medical care in Israel and to become acquainted with staff members of three institutions.

Participants will go by airline, and stopovers have been provided in Paris Istanbul, Athens and Rome. Sightseeing trips to the major points of interest in each area have been arranged.

Inquiries concerning the Israel tour may be addressed to: Dean of Continuing Education in Medicine, UCLA Medical Center, Los Angeles, 24, California (BRadshaw 2–8911, Station 7114).

Clinical Tour to Orient

The 24th annual meeting of The New Orleans Graduate Medical Assembly will be held March 6, 7, 8, and 9, 1961, with headquarters at The Roosevelt Hotel.

Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include 57 informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, medical motion pictures, round-table luncheons, scientific exhibits and technical exhibits.

Following the meeting in New Orleans, arrangements have been made for a clinical tour to the Orient leaving New Orleans via air on March 10, to make a connection with Jet flight leaving Los Angeles at night. The itinerary includes visits to Hawaii, the Philippines, Hong Kong and Japan, re-

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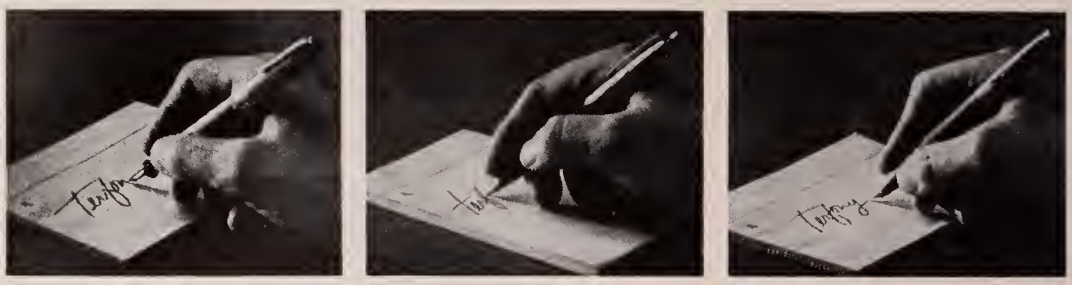

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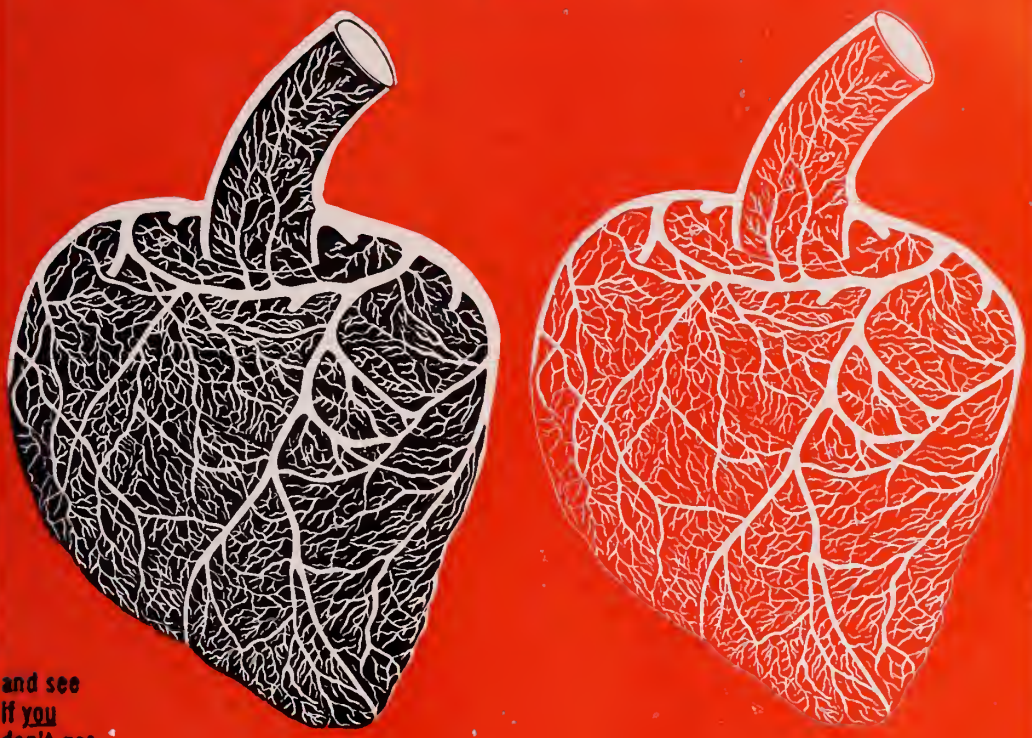

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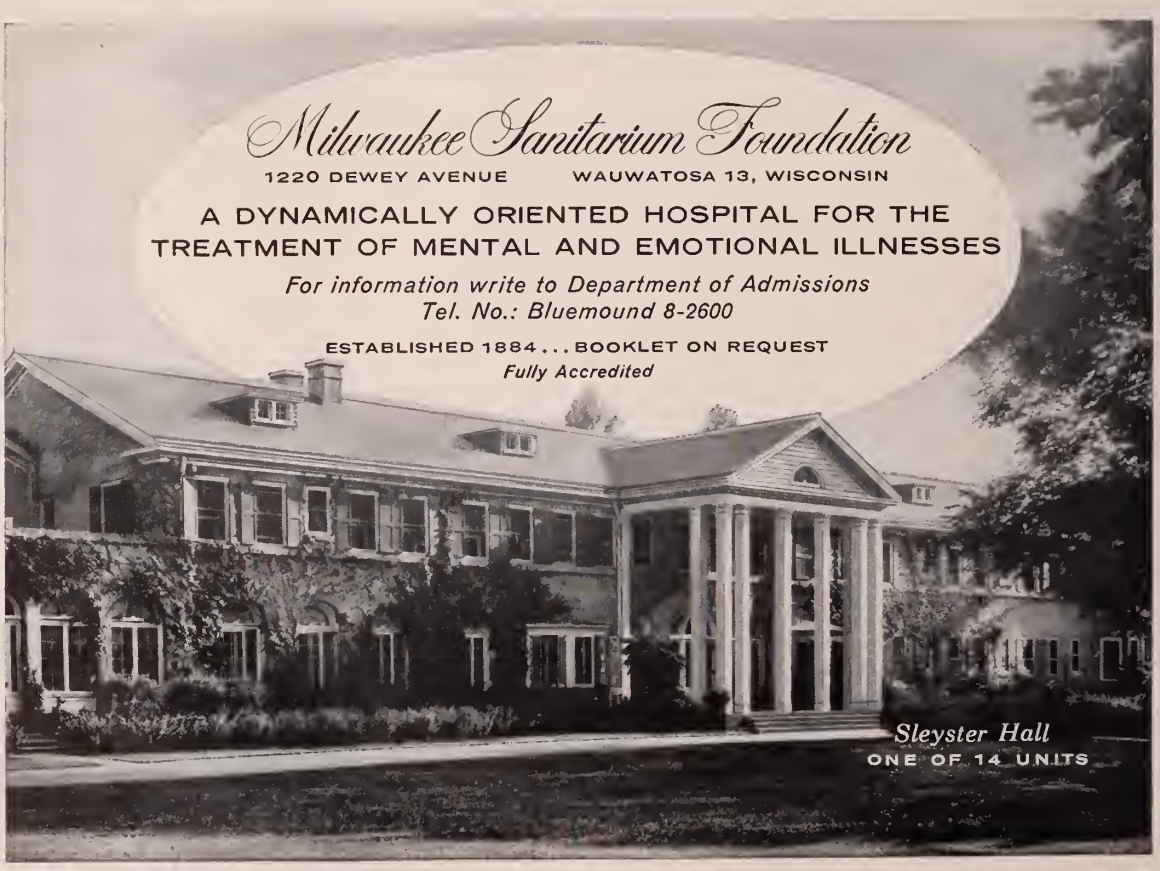

the Wisconsin Medical Journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

VOL. 60, NO. 2—FEBRUARY 1961

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EDITORIAL COMMENT

To Doctor Goldstein:

I would like to belatedly thank you for the space and comments you gave us, editorially, on the Basil MacLean-Blue Cross interview. There has been a good deal of comment on what we had to say but, by all odds, yours was the most provocative.

Thanks again.

WILLIAM H. WHITE
Executive Editor
Medical World News
30 Rockefeller Plaza West
New York, 20, N. Y.

RACINE MEDICAL SOCIETY

To SMS:

During the past year our society embarked on a study of the political, economic and social aspects of hospital and medical care for the aged and factors contributing to the inflationary trend in hospital and medical insurance. In the course of this study, programs were presented by:

1. Representatives of the Wisconsin Physicians Service who discussed Forand-type legislation and current problems of the Wisconsin Physicians Service Plans.
2. The Insurance Committee of the Racine Manufacturers Association which reported on the problem of increasing costs of hospital and medical care and the factors contributing to the inflationary trend.
3. Congressional candidates Richard Harvey, Jr., Edward Zahn, Gerald Flynn and Henry Schadeberg, who spoke on the subject of "The Problem of Hospital and Medical Care for the Aged." Presenting the position of the AMA was Mr. William McAuliffe of the AMA legal staff.
4. A symposium consisting of E. L. Belknap, M.D., Marquette University School of Medicine, William L. Lea, Ph.D., Director Industrial Hygiene Laboratory, and Mr. R. G. Knutson, Commissioner Wisconsin Industrial Commission, on the subject of Economic Problems of Industrial Medicine.
5. James Brindle, Director of the Social Security Department of the U.A.W., Detroit, Michigan, who spoke on Labor's Goals in Hospital and Medical Care.

The purpose of these meetings was to acquaint the members of the society with the current and future problems of hospital and medical care and proposals advanced for their solution by interested persons and organizations.

These meetings were well attended by members of the society, and at several special meetings members' wives, local and regional labor leaders and representatives of the Dental Society and Hospital Administrators were invited to attend. As a result of the interest developed in these problems by the membership of our local society, it is likely that other county societies might consider similar topics for their medical meetings.

MR. JAMES E. CONGDON
Executive Secretary
Racine County Medical Society
205–6th Street
Racine, Wisconsin

MARCH OF MEDICINE

To Doctor Tenney:

I have just listened to your broadcast over the State Station. I enjoy your broadcasts very much especially when you deal with medical problems with children—and psychological problems as well.

However, today you ventured into a field not entirely medical which makes room for some exceptions to your remarks.

With respect to baby clinics and their origin and organization, I doubt very much that the medical profession played the role that you inferred that it did.

When our 33-year-old son was an infant in your city—Madison—baby clinics were not a completely going concern there. Dr. Dorothy Mendenhall, wife of Professor Mendenhall (chemistry), tried to interest the pediatricians of Madison in starting one. (Doctor Mendenhall, as you know was the author of the first pamphlet on "Baby Care" for the Children's Bureau.) But the pediatricians turned her down giving the reason that they were not letting themselves in for giving "free" medical care. Doctor Mendenhall, nevertheless went ahead and started the clinic by herself. The next year these same pediatricians came to her privately and wanted to "head" the clinic. She gave them each one a Saturday apiece!

Now really, Doctor Tenney, the decline in the infant rate began abruptly around 1890 in *all* our big cities upon the beginning of the pasteurization of milk. Thus, the sanitary engineers deserve as much or more credit for this event as does the medical profession.

And didn't many doctors oppose Doctor Semmelweis, even in his home city of Budapest, in his strange theories of how to reduce the maternal death rate? His techniques are now generally accepted. And my doctors here in Milwaukee opposed (some bitterly) the beginning of the "Blue Cross." They even opposed the "Medical Center" here, an insur-

ance plan for medical care. And now the State and Milwaukee County societies have insurance plans of their own.

Certainly the Medical Societies have done much and deserve credit for it. They have also learned much and have reversed their position on several things. And they have several things yet to learn—and to accept.

I have a brother who is a very successful doctor in San Diego, California. But he talks just like you do on your subject today.

It seems to me a bit tragic that the Medical Societies (led by a Doctor Fishbein) are too frequently lagging behind when they should be leading the procession.

PHILIP H. PERSON
Emeritus Professor of Sociology
University of Wisconsin–Milwaukee
4441 North 25th Street
Milwaukee 9, Wisconsin

P.S. Doctors and their organizations are certainly to be given credit for improvement in medical education as you reported. But we need *more*, as well as *better* doctors. How do we get them? PHP

To Mr. Person:

Thank you for your letter which has reached me through the good offices of radio station WHA.

I appreciate your comments on my program on "Doctors and Their Organizations" even though I must take slight exception to some of them.

Your account of Doctor Mendenhalls' efforts to start well baby clinics in Madison is not quite accurate. This I know because I attended that first meeting and was one of those who gave volunteer service for several years. You are correct in saying that objection to giving free service was voiced. But that was by one physician; and he is a general surgeon, *not* a pediatrician.

I quite agree that the pasteurization of milk was the big step forward in reducing infant mortality. But the gospel of clean milk was slow in spreading until physicians and visiting nurses teamed up in the Infant Welfare movement.

You are also correct in saying that the work of Semmelweis was not immediately accepted with great acclaim. Actually however, I believe that our own Oliver Wendell Holmes caught more hell than did Semmelweis. But are you familiar with the outstanding job done in Chicago by Dr. Joseph De Lee using the principles developed by Semmelweis and Holmes? This is another example of what I was talking about. But, as a matter of fact, mankind has spent the last 1960 years being slow to accept the teachings of a great teacher.

Again, thank you for taking the trouble to write. I believe we agree on many matters, but I feel sure that our good works outweight our poor.

If I can be of further service, please contact me.

H. KENT TENNEY, M.D.
Director, March of Medicine
State Medical Society of Wisconsin

MEDICAL LIBRARY FEATURE

To WMJ:

Doctor McDonnell has asked me to write you concerning the article in the *Wisconsin Medical Journal* about our medical staff library. Your article was called to the attention of the chairman of publications of the AHIL *Quarterly*, which is the publication of the hospital and institution division of the Amercan Library Association. She has written to ask us for an article about the contents and services of our library, and the Christmas gift idea.

We have sent in the requested article, and thought you would like to know that your publication of information about our library stimulated further interest in it.

(MRS.) JEAN V. HAWKINS, Librarian
Medical Staff Library
Waukesha Memorial Hospital
Waukesha, Wisconsin

BOOK REVIEW COMMENT

To Dr. T. S. Roberts:

The *Wisconsin Medical Journal* has published in the past a number of gratifying reviews of the volumes of the History of the U.S. Army Medical Department in World War II, and it is pleasant to be able to add your nice review of the first neurosurgical volume in the November issue to the collection. I think you have quite well understood what we are trying to do, and I am particularly pleased to have you emphasize the frankness with which the book is written. We do try to tell the truth, and all of it.

I shall see that the attention of the authors and editors is called to this review. I am sure they will be as pleased as I am over it.

JOHN BOYD COATES, JR.
Colonel Medical Corps
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FOUNDATION PROGRESS

ANOTHER WAY TO HELP

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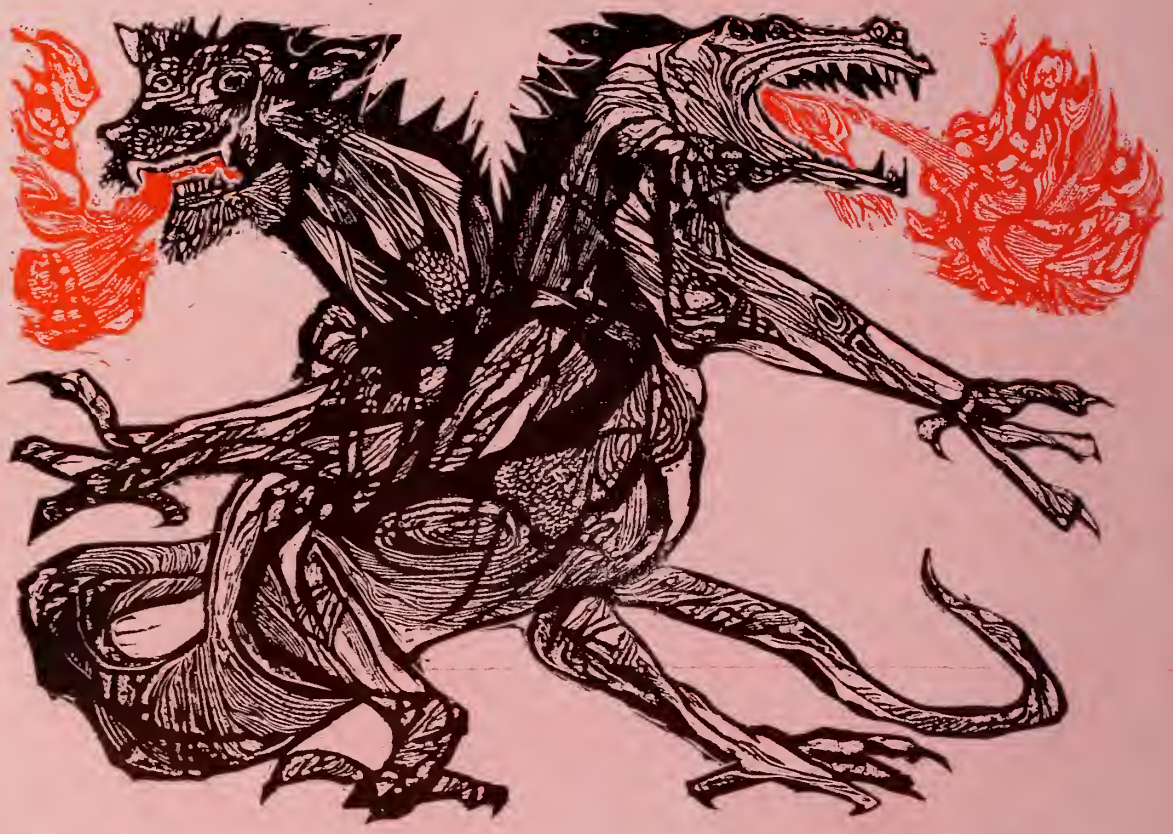

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BROWN

Dr. Ralph L. Troup was named president-elect of the Brown County Medical Society at the annual meeting at the Elks Club in Green Bay on December 8. Other officers are: *Dr. Emmet Killeen*, president; *Dr. Frank Urban*, secretary–treasurer, and *Dr. Louis Milson*, censor. Doctor Killeen succeeds *Dr. Jack Killins* as president.

The society paid tribute to three members who died during the past year: *Dr. E. S. Schmidt*, *Dr. M. H. Fuller* and *Dr. Henry S. Atkinson*.

At the November meeting, held November 10 at the Elks Club in Green Bay, 71 members and guests heard Dr. Loyal Davis, professor of surgery and chairman of the division of surgery at Northwestern University Medical School, present "Experiences in the Surgical Treatment of 1,700 Patients with the Intervertebral Disk Syndrome."

Dr. K. L. Zucker, Green Bay, reported on the Medical Civil Defense meeting which he attended in Chicago from November 4–6. Edward Teller, Ph.D., also talked on Civil Defense and stressed the need for a shelter program.

Dr. H. J. Kief, Fond du Lac, Councilor of the Sixth District, addressed the county society, calling attention to the serious lack of qualified students applying for admission to medical schools. He explained that "A Guide to Chapter 484 is being distributed to all State Medical Society members and called attention to action being taken through the State Board of Medical Examiners against unauthorized persons using the title "Doctor." Doctor Kief called attention to the medical Press Guide, and urged physicians to use it. A report covering actions of the House of Delegates, or State Medical Society committees, was shown. It listed projects which have been completed, are on a continuing basis, or are pending.

CHIPPEWA

Dr. M. W. Asplund of Bloomer was elected president of the Chippewa County Medical Society at a November 15 meeting at the Elks Club in Chippewa Falls. *Dr. Charles Kemper*, Chippewa Falls, was named vice-president and *Dr. Douglas Sallis*, Boyd, is secretary-treasurer. Doctor Asplund was named delegate to the State Medical Society and *Dr. John Sazama*, Chippewa Falls, is alternate.

Speakers at the meeting were *Doctors Ralph Frank* and *H. M. Aitken*, both of Eau Claire. The program was a Roentgen Symposium.

DANE

Leo Brown, director of the American Medical Association's Communications Division was the principal speaker at the January 10 meeting of the Dane County Medical Society held at the Maple Bluff Country Club, Madison. The dinner meeting was a combined session of the county medical society and woman's auxiliary.

At the society's December meeting, held at the Medical Center, University of Wisconsin, four papers were presented: "New Popular 'Chloroforms'" by *Dr. O. Sidney Orth*, Madison; "Cineangiocardiography and Congenital Heart Disease" by *Dr. George Rowe*, Madison; "The XXY Chromosome Constitution—Klinefelter's Syndrome" by *Dr. David Smith*, Madison; and "Is It True What They Say About Griseofulvin?" by *Dr. S. A. M. Johnson*, Madison.

At a November 4 meeting of the Dane County Medical Society's Foundation for Medical Research, Inc., the following officers were elected: *Dr. Robin N. Allin*, president; *Dr. Palmer R. Kundert*, vice-president; *Dr. William B. Parsons, Jr.*, secretary; and *Dr. Henry A. Peters*, treasurer. Funds from the Joss Memorial Research Foundation will become available in the spring of 1961 through the Dane County Foundation. Inquiries concerning contributions and the establishment of separate memorial funds within its structure can be obtained from any of the officers of the Foundation.

Opening of the Dane County Cytology Center was announced December 19. Organized by the county society, the center is operated on a nonprofit basis by Madison pathologists: *Drs. Edward Brucker, Dean Connors, Philip Piper, Donald Stevenson* and *E. L. Schafer*. Primary purpose of the center will be to test for cancer of the cervix by use of the Papanicolau method of smears. A charge of $4 will be made for each test.

DODGE

The Beaver Dam Medical Forum met on Monday, November 21. A short business meeting was conducted by the president, *Dr. R. I. Bender*. Speaker of the evening was *Dr. H. G. Bayley*, who spoke on the subject, "Treatment of Tuberculosis in Children." Doctor Bayley reviewed the most recent thinking of national leaders in tuberculosis control. He stated that the time was ripe to push for the elimination of tuberculosis in the United States. The major portion of his paper was directed toward the latest concepts in the treatment of tuberculosis in children. He reviewed the anti-tuberculosis drugs and specified the type and extent of treatment to be given for the various types of tuberculosis seen in children. He reviewed tuberculin testing in children and gave a brief discussion on the surgical aspects of treatment. He closed by stressing the importance of early detection and prophylaxis in the hope that ten years from now only one percent of our 14-year-olds will react to tuberculin testing.

Physicians whose names appear in italic are members of the State Medical Society.

DODGE

A review of the recent literature on phenylketonuria was given at the Januray meeting of the Beaver Dam Medical Forum by *Dr. E. R. Taake.* A summary of his talk follows:

Phenylketonuria's most striking clinical manifestation is severe mental deficiency. This sign in the presence of phenylpyruvic acid in the urine constitutes the syndrome of phenylpyruvic oligophrenia, This disorder has received much attention and a position of importance of late. This can be attributed to two important facts.

First, the disease can be detected easily early in life, even before the onset of mental retardation.

Second, if the disease is diagnosed early, proper dietary management actually can prevent mental deficiency. Thus, phenylketonuria can rightly be called one of medicine's footholds in the prevention of mental deficiency.

The medical world, particularly those interested in the field of mental retardation, took up the study of analyzing the patients in existing institutions for mental defectives. It was found that an amazing 0.5 to 1% of the patients in such institutions had this particular disease. It was estimated from these statistics from mental institutions and general population survey that this disease occurs once in about every 20,000 live births.

The clinical picture is that of a hyperactive, irritable, destructive, autistic, blond, mentally retarded child with a characteristic stale, musty odor about him.

The cause of phenylketonuria has been attributed to abnormally high phenylalanine blood levels produced by a metabolic block of phenylalanine to tyrosine.

The treatment is simply to place these children on foods of low phenylalanine content. The length of time for treatment is unknown.

It is interesting to note that if phenylketonuria is discovered early and mental retardation prevented, approximately $100,000 in cost to the state can be saved because the child will not need lifetime institutionalization.

GREEN LAKE–WAUSHARA

Dr. Thomas Kemp, Madison, spoke to the Green Lake–Waushara County Medical Society at their November meeting on the subject of "Common Dermatologic Problems Seen In General Practice." Starting the new year for the society, *Dr. Dowe Peter Cupery* of Markesan will serve as president and *Dr. David Sievers* of Berlin as secretary.

JEFFERSON

Dr. Roland Liebenow, Lake Mills, was elected president of the Jefferson County Medical Society at a dinner meeting held at the Meadow Springs Golf Club in Fort Atkinson December 15. *Dr. John H. Becker,* Watertown, was named secretary–treasurer.

LA CROSSE

Dr. Charles W. Mayo, Rochester, Minnesota, listed the "expense of being sick" and "the future supply of doctors" as the two major hurdles still facing the medical world when he spoke before the La Crosse County Medical Society in November. His talk, entitled "The Future of Medical Care In An Exploding Population," was sponsored by the Adolf Gundersen Foundation. In regard to cost, Doctor Mayo said, "As yet, there has been no leveling off of expense of being sick, and it behooves every doctor to be alert to adopt any measures, or to dispense with any measures, that may save expense for the patient provided such change does not detract from the quality of medical care." Concerning medical education, he stated that by 1975 the nation will need 11,000 medical school graduates a year contrasted to 7,400 completing training this year. He predicted that the nation "may be more dependent" upon foreign medical graduates by 1975. Doctor Mayo urged that any solutions to the problems must "stand the test of time" and be within the framework of "our voluntary way of life, the free enterprise system and decentralized government controls."

In a recent action the La Crosse County Medical Society named a committee to work with the County Board committee studying county medical costs. The board named a committee in November to consider the medical costs and advisability of having its own medical staff for county institutions and for welfare and relief recipients. Named to the committee by the medical society are *Drs. R. L. Gilbert, B. E. Lloyd, William Gallagher, Lou R. Schmidt,* and *S. E. Sivertson.* Doctor Lloyd is from West Salem and the other physicians each represent a different La Crosse hospital staff. In his letter to the County Board, announcing appointment of the committee, Society President *Dr. P. D. Anderson* stated, "This committee is at the service of the County Board and would like to assist in any regard with the welfare or any other committee you may appoint." We pointed out that action to establish a county medical staff would affect every welfare patient who might be deprived of free choice of physician, as well as every physician in the county.

LAFAYETTE

At the December 6 meeting of the Lafayette County Medical Society the following officers were elected: *Dr. L. L. Olson,* Darlington, president; *Dr. N. A. McGreane,* Darlington, vice-president; and *Dr. D. F. Ruf,* Darlington, secretary–treasurer. Doctor Olson was named delegate and *Dr. R. E. Hunter,* alternate delegate, to the State Medical Society's House of Delegates.

In other business transacted at this meeting, the members accepted the county medical society Constitution as drafted.

MILWAUKEE

Dr. James M. Sullivan was installed as president of The Medical Society of Milwaukee County at a December 8 meeting at the Wisconsin Club. He succeeds *Dr. N. Warren Bourne*, who was named to the board of directors.

Named president-elect of the society was *Dr. Roman E. Galasinski. Dr. I. J. Ricciardi* was elected secretary; *Dr. W. J. Houghton*, treasurer; and *Dr. W. L. Coffey*, to a one-year term, and *Dr. G. D. Straus*, to a two-year term on the Committee on Credentials.

Delegates to the State Medical Society are: *Drs. R. F. Purtell, S. L. Chojnacki, D. M. Willson, A. J. Sanfelippo, Edgar End, S. W. Hollenbeck, F. A. Ross, C. M. Schroeder, V. L. Baker, H. F. Twelmeyer, L. R. Weinshel*, and *H. M. Klopf*. Alternates are: *Drs. E. D. Wilkinson, S. E. Zawodny, J. R. Evrard, J. J. Barrock, D. J. Carlson, O. G. Fais, N. G. Bauch, K. E. Sauter, R. T. Sproule, D. W. Calvy, W. S. Polacheck*, and *B. J. Peters*.

At the November meeting of the society, annual dues were increased for the first time since 1951. Junior and Senior members will now pay annual dues of $35. For County Associate members the dues are $10, for Educational members the dues are $5 and for Resident and Intern members, $2. The recommendations made were the result of the Membership Committee's study of the dues structures of 24 metropolitan county medical societies and all state societies in the country. Increased activities in the fields of socio-economics, legislation, public relations, health education and membership services have resulted in increased annual expenses, the Board of Directors stated.

Milwaukee physicians witnessed a double "first" in educational television January 12 when the scientific meeting of The Medical Society of Milwaukee County was televised by WMVS–TV (Channel 10) from 8:30 to 9:30 p.m. This was the first remote live telecast produced by Milwaukee's educational television station and the first time in the nation a county medical society meeting has been telecast on open circuit television.

The program was presented by Dr. Warren H. Cole of Chicago who discussed "Newer Trends in Cancer Therapy." The telecast originated from the regularly scheduled January meeting at the Wisconsin Club. It was supported by a grant from the Pfizer Laboratories in the interest of postgraduate medicine.

A talk by *Dr. John S. Hirschboeck*, dean of the Marquette University School of Medicine, on "Marquette Medical School and Its Relationship to Medical Practice in Milwaukee County" preceded the scientific program and telecast.

Doctor Cole is professor and head of the department of surgery at the University of Illinois College of Medicine and surgeon-in-chief at the college's Research and Educational hospital.

OZAUKEE

Members of the Ozaukee County Medical Society heard *Dr. William H. Frackelton*, Milwaukee talk on "Salvaging the Injured Hand" at their October 27 meeting. His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society.

At the November meeting of the society *Dr. R. J. Millen*, Milwaukee, spoke on "Headaches, Their Differential Diagnosis and Treatment." Doctor Millen's appearance was also sponsored by the Foundation.

PIERCE–ST. CROIX

Dr. Charles F. McCusker, Glenwood City, was named president of the Pierce–St. Croix County Medical Society at a November 15 meeting in River Falls. Named vice-president was *Dr. Dean M. Ericksen*, St. Croix Falls, and *Dr. P. H. Gutzler*, River Falls, was elected secretary. Delegate to the State Medical Society is Doctor Gutzler and alternate is *Dr. O. H. Epley*, New Richmond. *Dr. J. H. Armstrong*, New Richmond, addressed the society on the Student Loan Fund of the Charitable, Educational and Scientific Foundation of the State Medical Society.

Dr. Vern Smith showed movies at the January 17 meeting of the Pierce–St. Croix County Medical Society meeting held at Rivers Edge in Somerset.

POLK

Members of the Polk County Medical Society were guests of *Dr. K. K. Ford* of Amery at a dinner meeting November 17. Speaker was *Dr. Frederic E. Mohs*, Madison, on the subject "The Chemotherapy of Cancer." A round table discussion followed Doctor Mohs' talk. Discussion on the Polk–Barron County Mental Health Clinic was also held. The clinic is scheduled to start next summer at Turtle Lake.

At their December meeting society members were guests of *Dr.* and Mrs. *Orrin Arneson* at the annual Christmas meeting. The Auxiliary brought gifts to be sent to mentally retarded and handicapped children.

RACINE

Dr. Joseph D. Postorino was named president of the Racine County Medical Society on November 17. President-elect is *Dr. F. M. Hilpert;* vice-president, *Dr. Warren Williamson;* secretary, *Dr. Ernest MacVicar;* and treasurer, *Dr. Leslie Jones. Drs. Frank Scheible* and *John Jamieson* were elected to the Executive Committee. Named delegates to the State Medical Society were: *Drs. Louis Fazen, Jr.*, and *Glenn Rothenmaier*. Alternates are *Drs. V. Burch* and *William Henken*. Acting as Censors are *Dr. Elizabeth Steffen*, chairman, and *Dr. William J. Madden. Dr. Richard Meyer* replaced *Dr. Gordon Schulz*, whose term expired as of 1960.

At a special dinner meeting on November 22, members of the society heard James Brindle, Detroit, director of the Social Security Department of the United Auto Workers, speak on Labor's goal in hospital and medical care. Representatives of the Racine County Dental Society, hospital administrators, and local and regional labor leaders were invited to attend. George Cooley, director of the Department of Medical Service of the American Medical Association participated in the discussion. Brindle called for medicine and organized labor to cooperate in "experimentation with all kinds of programs" to bring about a workable, comprehensive program of voluntary medical insurance for the working man. He added that he sees "little possibility" of achieving compulsory coverage under social security, even though organized labor is on record favoring such a plan.

Brindle suggested that the medical profession "firm down" and stabilize cost of its services. He also said overuse of hospital beds should be cut down through careful screening by the medical profession. Problems from the workers' viewpoint include increased premium costs, "gaps" in coverage, and "extra charges" by hospitals and doctors for items that are insured. Calling for more experimentation in health insurance, Brindle added that the UAW is working on a complete coverage prepayment plan in Detroit. The UAW spokesman and AMA's Cooley disagreed somewhat on the need for major medical coverage plans. Brindle termed them "the antithesis" of good medicine on the basis that people would neglect care in less serious illnesses. Cooley stated that major medical plans attack the real problem, cost of major hospitalization. He added, however, that they should accompany coverage for less costly care.

ROCK

Dr. Paul F. Hausmann, Milwaukee, spoke at the meeting of the Rock County Medical Society November 29 in Janesville on "Acute Thoracic Emergencies." His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society.

SAUK

The Sauk County Medical Society met on Tuesday, January 10, at which time 19 members heard a lecture by *Dr. Ben Lawton* of the Marshfield Clinic. During the business session nursing scholarships were discussed which resulted in increasing the amount to $400.

SAWYER–BARRON–WASHBURN–BURNETTE

Members of the Sawyer, Barron, Washburn and Burnette County Medical Society heard *Dr. R. F. Schilling*, Madison, talk on "Effective Therapy Treatment of Anemias" at a meeting November 8. The meeting was held at the Elks Club in Rice Lake. Doctor Schilling appeared under the sponsorship of the Charitable, Educational and Scientific Foundation of the State Medical Society.

TREMPEALEAU–JACKSON–BUFFALO

Dr. Roland Thurow was named president-elect of the Tri-County Medical Society at the annual meeting November 22 in Independence. *Dr. William Wright* became president of the county society on January 1. Other officers elected are: *Dr. John H. Noble*, secretary–treasurer; *Dr. Elmer Rohde*, delegate; *Dr. William Wright*, alternate; *Dr. M. O. Bachhuber*, censor; and *Dr. O. M. Schneider*, public relations officer.

WINNEBAGO

A paper on obstetrics was presented by *Dr. William V. Luetke*, Madison, at a meeting of the Winnebago County Medical Society November 3 at Valley Inn in Neenah. Doctor Luetke is assistant clinical professor of obstetrics and gynecology at the University of Wisconsin Medical School. His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society.

WOOD

Dr. John Allen, medical consultant to the State Department of Public Welfare, was guest speaker before the Wood County Medical Society December 8 in Marshfield. In other events at the meeting, *Dr. E. C. Glenn*, Wisconsin Rapids, was elected delegate and *Dr. W. B. Larkin*, Marshfield, alternate delegate to the State Medical Society.

WISCONSIN ALPHA OMEGA ALPHA INITIATION CEREMONIES

The Wisconsin Chapter of Alpha Omega Alpha will hold its annual initiation ceremonies on March 3. Dr. George W. Thorn, noted Harvard endocrinologist, will present the Convocation in the SMI Auditorium, University Medical School, at 4:00 p.m. Everyone is welcome to attend. A short initiation, open to all AOA members, will be held in the seminar room of the Bardeen Laboratories immediately following the Convocation. There will be a banquet that evening with Doctor Thorn and the new initiates as guests. Any AOA member wishing to attend the banquet should contact Miss Crane, secretary of the Surgery Department, before March 1, for reservations.

Milwaukee Oto-Ophthalmic Society

Members of the Milwaukee Oto-Ophthalmic Society met January 24 at the University Club of Milwaukee for dinner followed by a meeting and scientific program. Guest speaker was *Dr. R. P. Gingrass*, professor of oral and maxillo facial surgery at the Marquette University School of Dentistry, Milwaukee. His subject was "Injection and Surgical Treatment of Tempero-mandibular Joint Derangements."

Milwaukee Neuro-Psychiatric Society

The subject "Review of Nine Years Experience with Wisconsin Sex Crimes Law" was presented by *Dr. Seymour L. Halleck* to members of the Milwaukee Neuro-psychiatric Society at their monthly meeting held January 18 at the University Club of Milwaukee. Doctor Halleck is director of Psychiatric Field Service, Division of Corrections of the State of Wisconsin.

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Physicians whose names appear in italic are members of the State Medical Society.

Milwaukee Academy of Medicine

The following are the officers of the Milwaukee Academy of Medicine for 1961: president, *Dr. George C. Owen;* president-elect, *Dr. C. Sherrill Rife;* vice-president, *Dr. Francis F. Rosenbaum;* secretary, *Dr. Donald M. Ruch;* treasurer, *Dr. Robert A. Frisch;* librarian, *Dr. P. Jackson Stoddard;* and chairman of the membership conmmittee, *Dr. Paul G. LaBissoniere.*

Council members are: *Drs. Edward A. Birge, David Cleveland, William W. Engstrom, Frederick E. Foerster, Paul F. Hausmann,* and *Herbert W. Pohle.*

These officers and Council members were elected at the Academy's annual meeting held at the University Club of Milwaukee on Tuesday, January 17.

The Milwaukee Academy of Medicine held a meeting December 6 at the University Club of Milwaukee. Speaker was Dr. Richard V. Ebert, head of the Department of Medicine, University of Arkansas School of Medicine. His topic was "The Criteria of Truth—The Evaluation of a Therapeutic Agent." Clinics were held December 7 at the Milwaukee County General Hospital and December 8 at the Veterans Administration Hospital by the Academy.

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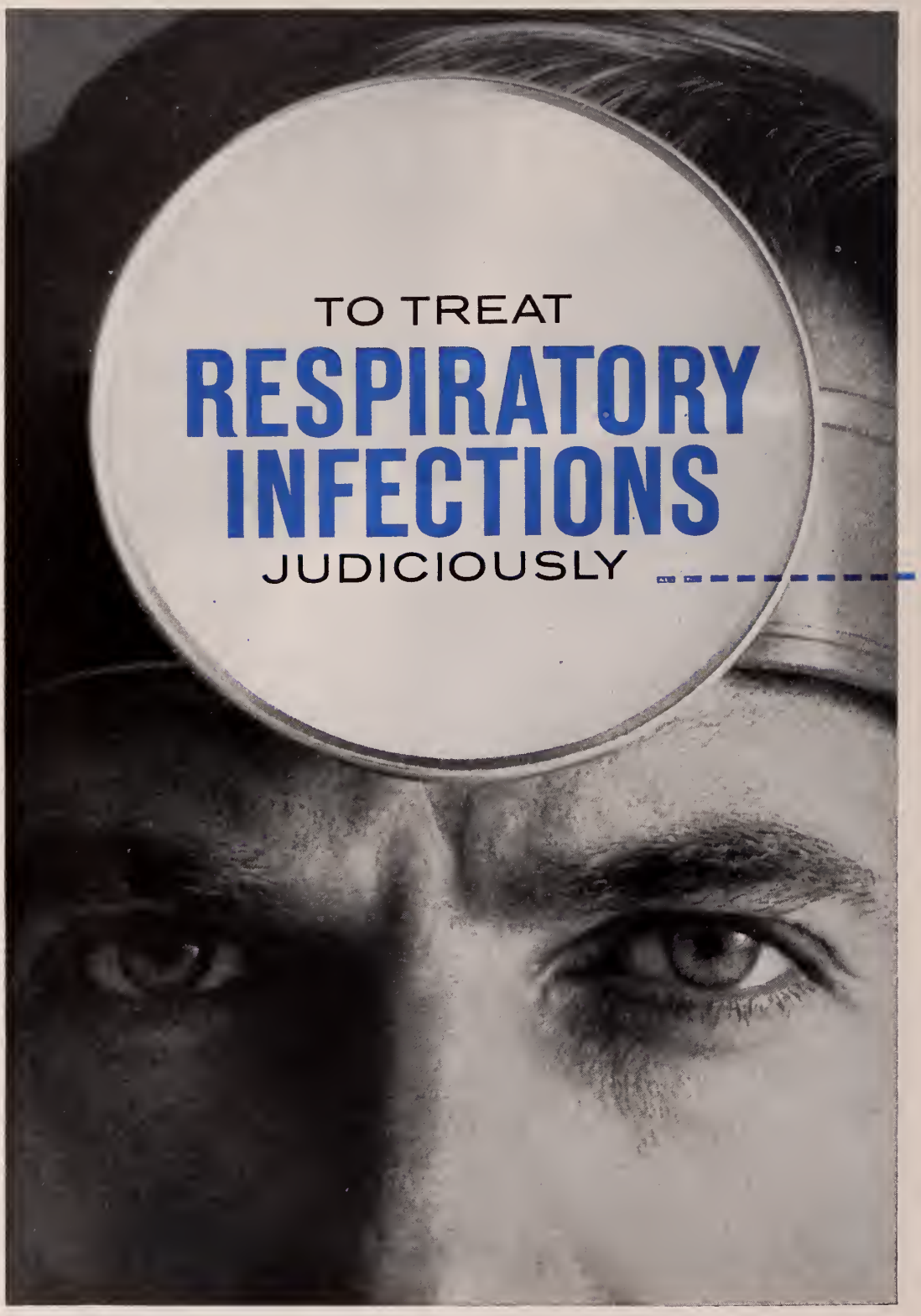
TO TREAT
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INFECTIONS
JUDICIOUSLY

NEWS OF WISCONSIN PHYSICIANS

Officer in Military Surgeons

Dr. William S. Middleton, chief medical director of Veterans Administration, Washington, D.C., and a former dean of the University of Wisconsin Medical School, Madison, was elected a fourth vice-president of the Association of Military Surgeons of the United States for 1961 at the 67th annual meeting held in November, 1960.

Maternal Mortality Institute Participants

Participants in the Maternal Mortality Institute held at Green Bay January 19 are: *Dr. T. A. Leonard*, Madison, chairman of the MM Study Committee of the State Medical Society; *Dr. William Kreul*, Racine; *Dr. Samuel G. Perlson*, Milwaukee; *Dr. George G. Rowe*, Madison; and *Dr. Ben Peckham*, Madison.

Topics were: "The Obstetrician and General Anesthesia," "Infections as a Cause of Maternal Demise," "The Management of Cardiac Problems During Pregnancy," and "Unexpected Massive Hemorrhage."

The program was presented by the State Medical Society, The Wisconsin State Board of Health and the Wisconsin Academy of General Practice.

Officers of Gastroenterology Group

Dr. Irvin M. Becker, Milwaukee, has been elected president of the Milwaukee Chapter of the American College of Gastroenterology, succeeding *Dr. Robert T. McCarty*, Milwaukee. Other officers include: *Dr. Philip B. O'Neill*, vice-president; and *Dr. Charles J. Sherkow*, secretary-treasurer, both of Milwaukee.

Talks To Attorneys On Physician Witnesses

Members of the Brown County Bar Association at their October 11 meeting heard *Dr. James W. Nellen*, Green Bay orthopedic surgeon, tell of the difficulties physicians have in serving as court witnesses in automobile accident cases. Doctor Nellen urged attorneys to notify physicians well in advance when they are to appear and to interview them about the case before the courtroom appearance. He also stated that there is a tendency to use medical specialists too often on the witness stand. The general practitioner, who is usually the attending physician in the case, often is the best witness, he said.

Dr. Klein Joins Hazel Green Clinic

Dr. G. J. Klein, West Virginia, joined the staff of the Hazel Green Clinic and Hospital on September 30. For the past two years Doctor Klein headed the Department of Gynecology and Urology of the Beckley Hospital at Beckley, West Virginia. From 1952 to 1958 he received postgraduate training in surgery at the University of Michigan, Ann Arbor, Michigan; St. Joseph's Mercy Hospital, Pontiac, Michigan; and the Beckley Hospital.

Physicians whose names appear in italic are members of the State Medical Society.

Former Wisconsinite Goes To India

Dr. Harry K. Purcell, a former Madison resident, is now in India, serving as surgeon at a Catholic mission hospital in New Delhi. Doctor Purcell is the son of the late Dr. Harry Purcell, formerly Madison city health officer and a practitioner in that community. Prior to leaving for India, Doctor Purcell was an associate professor at St. Louis University Medical School. In addition to his surgical work at the missionary hospital, he will set up a training school for native physicians and nurses.

New Fellows in College of Surgeons

Fifteen Wisconsin physicians were inducted as new fellows into the American College of Surgeons during the annual five-day clinical congress in San Francisco last October.

They are Doctors *Lyle D. Milliken, Jr.*, Kenosha; *Thomas E. Lynn* and *Richard H. Troup*, Green Bay; *Robert H. Cassidy, John D. Hurley, Foster J. Jacobson, Edwin H. Schalmo, Jack Teasley, Raymond R. Watson* and *Gerald R. Zupnik*, all of Milwaukee; *Gordon H. Hardie*, Neenah; *Ernest J. Zmolek*, Oshkosh; *George F. Pratt*, Rhinelander, *Joseph J. Mueller*, Milwaukee and A. Stephen Close, Wood.

Dr. Samp Talks To School Group

Dr. Robert J. Samp, Madison, medical and scientific director of the Wisconsin Division, American Cancer Society, and assistant professor of surgery, University of Wisconsin Medical School, recently talked to the students of Farnsworth Junior High School, Sheboygan, on the subject of smoking, as it relates to health and longevity. He pointed out that 80 per cent of all junior and senior high school students try smoking at some time or other between the ages of 12 and 18. He stated that parents who smoke and mass media advertising give the students the mistaken idea that smoking is a normal and non-health-connected habit instead of an addiction shown to have a direct correlation with health problems and even length of life.

Dr. Hirschboeck Speaks to MU Club

Dr. John S. Hirschboeck, dean of Marquette University School of Medicine, was the speaker at the Duluth–Superior Civic Committee for Marquette University on October 19.

Dr. Stoops Talks To Scandinavian Club

Dr. Charles W. Stoops, president of the Dane County Medical Society, spoke before a meeting of

the University of Wisconsin Scandinavian Club October 19 in Madison. His topic was "The Case Against National Compulsory Health Insurance."

Dr. Bryant Attends Surgical Congress

Dr. and Mrs. *R. J. Bryant* of Durand attended the Pan-Pacific Surgical Association Congress in Honolulu, Hawaii, September 27 to October 5. The Congress attracted 1,455 delegates.

Honored guests at a banquet of the Wisconsin Council of Agriculture Cooperative are pictured above left to right: Arthur N. Johnson, River Falls; Frances Zuill, Madison; C. J. Chapman, Madison; and Dr. Spencer D. Beebe, Sparta.

Agricultural Cooperatives Honor Dr. Beebe

The Wisconsin Council of Agriculture Cooperative honored *Dr. Spencer D. Beebe* at a banquet in Madison October 27 for his efforts in bringing about better rural living. Doctor Beebe has been a physician for 64 years in Elroy and Sparta.

The citation reads, "To Spencer D. Beebe, true symbol of the country doctor in America, community benefactor, spiritual leader, dispenser of happiness, humanitarian and crusader for the finest principles of living, we present this evidence of our esteem."

Doctor Beebe's medical career was reviewed at the banquet, held in the Loraine Hotel in Madison, by Truman Torgerson, president of the Wisconsin Council of Agriculture Cooperative. The tribute also included mention of his participation in the activities of the State Medical Society of Wisconsin and his many efforts in the field of music and establishment of the non-denominational "services under the trees" religious program which has been held for 30 years in Sparta.

"As a physician, Doctor Beebe has combined selfless devotion and compassion with outstanding professional ability," said Mr. Torgerson. "His constant sense of humor, his good cheer and his living example of high ideals have combined to build a stature of significant influence reaching beyond his community to the state and the nation."

Dr. Newcomb Subject Of Television Show

Filming began in October for an hour-long special television program, based on the life of the late Dr. Kate Pelham Newcomb. Doctor Newcomb practiced in the Woodruff, Boulder Junction and Minocqua areas prior to her death. A best-selling novel, "Dr. Kate, Angel on Snowshoes," has already been written about her career, and she was once the subject of a "This Is Your Life" program.

Dr. Palmer Joins Clinic At Menomonie

Dr. Karl Palmer, Graceville, Minnesota, joined the Red Cedar Clinic at Menomonie on November 1. He is a 1955 graduate of the University of Minnesota Medical School. Doctor Palmer will take the place of *Dr. K. H. Neldner* who is taking a three-year residency at the Mayo Clinic.

Dr. Squier Honored By Allergy Society

Dr. Theodore Squier, Milwaukee, was presented a certificate of merit as a pioneer in the field of allergy study at the first meeting of the newly formed Wisconsin Allergy Society held in Madison on October 15.

Speaks At Medical Assistants Meeting

Dr. H. A. Weisse, Plymouth, conducted a workshop for members of the Washington-Ozaukee-Sheboygan County Medical Assistants Society on October 11. The meeting was held at the Plymouth clinic.

Resolution Honors Doctor Heidner

A resolution honoring *Dr. A. H. Heidner*, West Bend, was unanimously adopted by the Congress of Delegates of the Wisconsin Academy of General Practice in Milwaukee. This is the first time the organization had ever passed a resolution commending one of its members in the 13-year history of the group. He was honored for his service both to the people and the medical profession of Wisconsin.

Doctor Klopf Hits Government Control Of Medicine

"The greatest challenge facing physicians today is the government control of medicine," *Dr. Howard Klopf*, president of the Milwaukee Academy of General Practice, told the members of the Brookfield-Elm Grove Chamber of Commerce at their annual meeting in October. "Our country is the healthiest in the world," he said. "It should not be held back by government restrictions."

Dane County AAGP Elects Doctor Derus

Dr. Gerald Derus, Madison, was elected president of the Dane County chapter of the American Academy of General Practice at the group's annual meeting in October. Other officers elected were *Dr. James Moore*, Madison, secretary, and *Dr. Lloyd Kellogg*, Oregon, treasurer. The chapter is considering a program to help meet the problem of the relatively low number of medical students who wish to become family doctors.

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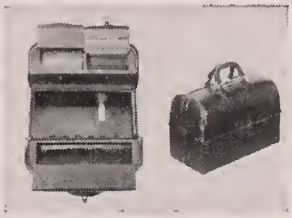

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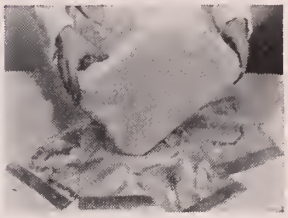

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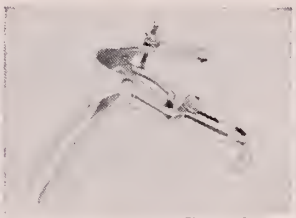

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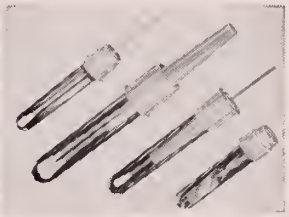

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Erect New Clinic In West Salem

Dr. B. E. Lloyd and *Dr. D. L. Morris* are erecting a new clinic in West Salem. The 45-by-69-foot structure will have 17 rooms. It is expected to be ready for occupancy this spring.

Dr. Strakosch Talks On Care Of Aged

Dr. Ernest A. Strakosch, Oshkosh, talked on medical care for the aged November 16 before the Eastern Wisconsin Welfare Association at a meeting in New Holstein. Doctor Strakosch debated with Dr. Joseph Sheridan of Chicago. Both agreed that elderly people need medical care, but disagreed on the manner in which it should be provided. Doctor Strakosch opposed a Federal program, stating that the community knows the individual needs and could do a more adequate job on the home basis. He told of a survey taken in Georgia that showed nine out of ten persons over 65 had no unfulfilled needs and a large percentage of the others could pay for emergency operations out of their own funds.

Doctor Alvarez Speaks At Onalaska

Dr. R. L. Alvarez, Galesville, spoke before the Onalaska Rotary Club November 14, advising them on the action the community could take to attract a general practitioner to the town. Doctor Alvarez pointed out that the trend in medicine is toward specialization rather than general practice. He suggested that the community look into the possibility of building a clinic to attract physicians.

Dr. Stula Still Has Residence Problem

Dr. Gojka Stula, international political refugee who is presently living in Milwaukee, may be required to leave the country by February 14. Doctor Stula denounced the communist regime in his native Yugoslavia in 1958, gave up his citizenship, and went to France for political asylum. From France, he came to this country, and is presently serving his residency at St. Luke's Hospital in Milwaukee.

The law requires foreign interns and physicians to return to their respective countries after completing training, and they cannot return to the U.S. for two years. Doctor Stula contends that he has no country to which to return. Action is presently being taken to introduce a bill in Congress to give Doctor Stula immigrant status and then he could remain in this country.

Two New Physicians At Marshfield

Dr. Darius Shahrokh and Dr. Rudolf Pyka have recently joined the medical staff of the Marshfield Clinic, bringing to 41 the number of specialists on the staff.

Doctor Shahrokh is an ear, nose and throat specialist and Doctor Pyka is an orthopedic surgeon. Both came to Marshfield from the Mayo Clinic in Rochester, Minnesota.

Dr. Saydjari Receives Honor

Dr. M. S. Saydjari of Barron became a fellow in the American College of Gastroenterology at a meeting in Philadelphia, Pennsylvania, on October 23. Doctor Saydjari also received a fellowship from the American Board of Abdominal Surgery.

Portrait Of Doctor Buerki Unveiled

Dr. Robin C. Buerki, Detroit, one of the driving forces behind organization and development of University Hospitals was in Madison November 4 to witness the unveiling and presentation of his portrait to the University of Wisconsin. The portrait, painted by Roy C. Gamble, now hangs in the hospital lobby.

Doctor Buerki came to Wisconsin in 1923 and participated in the planning and organization of Wisconsin General Hospital. He was superintendent of the hospital from 1923 to 1941, plus holding other posts in the University of Wisconsin Medical School. Doctor Buerki left Wisconsin in 1941 to become dean of the Graduate School of Medicine of the University of Pennsylvania. He is presently director of Henry Ford Hospital in Detroit.

Dr. Samp Talks On Cancer

Dr. Robert J. Samp, medical and scientific director of the Wisconsin Division, American Cancer Society, spoke in De Pere November 7 under the auspices of the Brown County unit of the cancer society.

Dr. Roethke In Powder Puff Derby

Dr. Anne E. Roethke, Milwaukee, was one of the participants in the 14th annual All Woman Transcontinental Air Race, better known as the Powder Puff Derby, which took place last July. Entered for the first time this year, Doctor Roethke and her partner, Mrs. Mary Landis, finished 33rd.

Physicians Present Milwaukee Lectures

Dr. Arthur Hankwitz and *Dr.* and Mrs. *Herman Heise* are participants in the Milwaukee Public Museum Lectures during the 1960–61 season. Doctor Hankwitz presented a lecture on "The Heart of Europe" on November 2, with a photographic presentation of the scenic and urban splendors of Europe. Doctor and Mrs. Heise talked on Hawaii January 11 and showed the prize winning film "Whither Flowing."

Dr. Petersen Joins Cuba City Clinic

Dr. Robert E. Petersen, of Dubuque, Iowa, has become associated with the Cuba City Clinic. A fellow of the American College of Surgeons, Doctor Petersen is certified by the American Board of Surgery. He will also maintain his regular surgical practice in Dubuque.

Green Bay Physicians' Paper Is Presented

Dr. Herbert Sandmire, Green Bay, presented a paper on "Prevention and Treatment of Postpartum

La Crosse Leader Tribune Photo

A retired La Crosse physician, Dr. E. E. Gallagher, left, receives an explanation of a "cofflator," a device to assist in ineffective coughing, from Dr. William Gallagher, right. Looking on are Dr. Robert McMahon and Dr. G. I. Uhrich, the latter president-elect of the St. Francis Hospital medical staff. This scene took place during the annual St. Francis Day meeting October 27 during which Dr. E. E. Gallagher was honored with a testimonial program for his 41 years of medical practice.

Hemorrhage" at the recent meeting of the Sixth District, American College of Obstetricians and Gynecologists, in Chicago. Authors of the paper were Doctor Sandmire and *Dr. Stephen Austin*, also of Green Bay. The paper is also being presented in the scientific section of this issue of the Journal.

Dr. Beck Heads United Fund

Dr. John Beck, Sturgeon Bay, was co-chairman of Door County's first United Fund drive, which exceeded its goal of over $26,000. Fifteen agencies participated in the drive.

Dr. Lubitz Discusses Problems In Medicine

Current problems in U.S. medicine were discussed by *Dr. Joseph Lubitz*, Brookfield, before the Waukesha County Unitarian Fellowship November 13. Using the Harpers magazine article "The Crisis in American Medicine" as a basis for the discussion, Doctor Lubitz also answered a series of questions prepared by Richard E. Davis, Oconomowoc Lake. The doctor is president-elect of the Wisconsin Association of Pathologists.

Obstetricians Elect Doctor Ellis

Dr. John C. Ellis, Madison, was elected president of the junior fellow division, District 6, of the American College of Obstetricians and Gynecologists. The organization held its annual meeting in Chicago in November.

Dr. Gallagher Honored At La Crosse

Seventy physicians and dentists paid testimony to *Dr. E. E. Gallagher*, La Crosse, at the annual St. Francis Day meeting on October 27. At the dinner, held at the St. Francis School of Nursing auditorium, *Dr. Lou R. Schmidt* reviewed the retired surgeon's career. The 69-year-old physician is a 1915 graduate of St. Louis University Medical School.

Dr. Ludwig Talks On Civil Defense

"Civil defense begins with you and me," and "the best assurance against panic in any emergency is training," *Dr. E. P. Ludwig*, Marathon County Civil Defense Medical Director told the Wausau Altrusa Club November 17. Doctor Ludwig is chairman of the State Medical Society's Committee on Disaster Medical Care. He explained that there are five simple steps to safety that every person should know: warning signals and what they mean, the individual community plan for emergency action, protection from radioactive fallout, first aid and home emergency preparedness, and the use of Conelrad for official directions.

Dr. Hankwitz Speaks to High School

Dr. Arthur Hankwitz, Milwaukee, spoke to members of the Bay View High School recently on the subject of becoming a physician. Doctor Hankwitz is well known for his civic enthusiasm.

Dr. LeTellier Talks to Visiting Nurses

Dr. Mason LeTellier, Green Bay, was guest speaker at the 32nd annual dinner meeting of the Green Bay Visiting Nurse Association held November 10. He reviewed the history of the association and predicted an expansion into industrial nursing in the future for the organization.

Wisconsin Physicians On Oklahoma Program

Dr. David T. Graham, associate professor of medicine at the University of Wisconsin Medical School, Madison, and Dr. Ben I. Heller, professor of medicine at Marquette University School of Medicine, Milwaukee, were guest consultants on a postgraduate educational program at the University of Oklahoma Medical Center December 15-17. The general subject of the meeting was "Consultations On Problems in Practice."

Dr. Altmeyer Addresses Mental Health Group

Dr. John Altmeyer, Milwaukee, addressed the Waukesha County Association for Mental Health December 1. Doctor Altmeyer, who became full-time director of the Waukesha County Mental Health Clinic in January, talked on the handling of children.

Dr. Bauer Heads Ladysmith Kiwanis Club

Dr. William Bauer was elected president of the Ladysmith Kiwanis Club on November 22.

Doctor Curreri Notes Progress Against Cancer

Real progress is being made in treatment of cancer with chemical agents, *Dr. Anthony Curreri*, director of the cancer research division of the Department of Surgery, University of Wisconsin Medical School, told the Madison Rotary Club November 30. The government alone is spending some $30 million this year in this country and abroad in study of chemotherapy as a means of combatting cancer, he said. He reviewed the joint efforts of the university and the McArdle Institute in cancer research.

Dr. Kobelt Joins Manitowoc Clinic

Dr. Carl C. Kobelt has joined the staff of the Manitowoc Clinic. A native of Chicago, Doctor Kobelt is a graduate of Illinois Medical College in 1954, he interned at Detroit Receiving Hospital and served his residency at Dearborn Veterans Administration Hospital and Detroit Receiving Hospital. Doctor Kobelt was in the Army from 1958 until October of 1960.

Physicians Appointed by American Cancer Society

Two Milwaukee physicians have been appointed to important positions by the American Cancer Society. *Dr. James E. Conley*, Fox Point, has been named chairman of the service committee for 1960–61. *Dr. John S. Hirschboeck*, Shorewood, has been named chairman of the annual scientific assembly which will be held in New York City in October of 1961.

Dr. Waisman Receives Leukemia Grant

Dr. Harry A. Waisman, Madison, has been awarded $3,000 for his study, "Enzyme Studies Related to Amino Acid Metabolism in Leukemia." The grant is one of eight awarded by the Leukemia Society, Inc., in its international research program.

Doctor Middleton Panelist

Dr. William S. Middleton, Chief Medical Director of the Veterans Administration, Washington, D. C., was a panelist during the October 31 session of the 67th Annual Meeting of the Association of Military Surgeons of the United States held October 31–November 1 and 2 at the Mayflower Hotel in Washington, D. C.

Dr. Demergian Joins Clinic

Dr. Vaughn Demergian recently joined the staff of the Jackson Clinic, Madison, in the department of plastic and reconstructive surgery. Previous to coming here, Doctor Demergian was in private practice in Los Angeles.

A graduate of the University of Wisconsin Medical School, Doctor Demergian served his internship at Abington Memorial Hospital, Philadelphia. He served with the U.S. Army Air Force from 1943 to 1946.

Doctor Demergian completed his general surgery residency at Cedars of Lebanon Hospital, Los Angeles, and a residency in plastic surgery at the University Hospitals, Madison, under Dr. Wayne Slaughter and Dr. Frank Bernard.

Doctor and Mrs. Demergian and their two sons are living at 4902 Altem Circle.

Former UW Student Honored

Dr. William C. Spring, Jr., Brooklyn, New York, has been appointed secretary of the American Medical Association's Council on Drugs. He assumed his new duties January 16. Doctor Spring attended the University of Wisconsin from 1931–1933 as a premedical student.

Doctor Spring was formerly serving as medical director of the laboratories division of the Chas. Pfizer & Co., Brooklyn. He succeeds Dr. Harold D. Kautz who resigned last July 20 to accept a position with Abbott Laboratories, North Chicago, Illinois.

Dr. Lee Allergy Committee Chairman

Dr. Howard J. Lee, Milwaukee, is chairman of the Postgraduate Education Sub-Committee of the American Academy of Allergy which held its annual meeting February 6–8 in Washington, D.C. A two-day postgraduate course was held preceding the annual meeting.

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with Campanula (Canterbury Bells) in foreground

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D 27

Dr. Klumper Radiation Therapy Director

The Sisters of St. Mary and The Radiation Center of Madison have jointly announced the appointment of Dr. William Klumper as director of radiation therapy.

Dr. Elsom New Medical Director

Dr. Kendall A. Elsom has been named to the newly-created position of medical director at Scott Paper Company, Chester, Pennsylvania. Doctor Elsom was graduated in 1924 from the University of Wisconsin where he served for a year as student instructor of physiology. He will also maintain his association with the University of Pennsylvania Hospital where he will continue a research project involving health examinations for executive personnel.

Dr. Quisling CC Board Member

Dr. A. A. Quisling, Madison, is a new member of the board of directors of the Wisconsin State Chamber of Commerce. His election came at the annual meeting of the group held October 27 in Milwaukee.

Associates with Doctor Cupery

Dr. Paul M. Plueddeman is now associated in general medical practice with *Dr. Dowe P. Cupery* at the Markesan Medical Center. Doctor Plueddeman recently completed two years of active duty in the Navy during which time he was stationed in San Diego. His home was formerly Rockford, Illinois, and he graduated from the University of Illinois College of Medicine in 1957. This was followed by a year of internship at Cincinnati General Hospital. Doctor Plueddeman is now a member of the Dodge County Medical Society.

Dr. Middleton Talks on VA Network

Dr. William S. Middleton, chief medical director of the Veterans Administration, Washington, D.C., on December 6, 1960, broadcast the first message to be heard over the new shortwave radio amateur network linking 30 VA hospitals in the United States. Shortwave radio is used in manual arts therapy, physical medicine and rehabilitation, for treatment of hospitalized veterans. The network will also provide an emergency means of communication in disaster periods and permit conversations between hospitalized patients and their families living some distance from the hospitals.

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OBITUARIES

Dr. Henry Stephen Atkinson, Green Bay physician, died October 30, 1960, at the age of 60.

Born in Green Bay in 1899, he was a graduate of Marquette University School of Medicine. Following internship at St. Mary's Hospital and Mercy Hospital in Milwaukee, he returned to Green Bay where he had practiced for the past 33 years. Doctor Atkinson was city physician there for 25 years and was team physician for the Green Bay Packers football team from 1944 until his retirement from that post this year.

A member of the Brown County Medical Society, he served as president in 1932 when it was a part of the Brown-Door-Kewaunee County Medical Society. He was also a member of the State Medical Society, the American Medical Association, and a past president of the Railway Surgeons Association.

Survivors are his widow and two sons, Thomas G. and Henry, Jr., both of Green Bay.

Dr. D. S. Van Hecke, Phillips, a general practitioner with a special interest in ophthalmology, died November 4, 1960.

Born November 15, 1889, in Merrill, he was a graduate of St. Louis University Medical School in 1916. After internship at Kansas City General Hospital, Doctor Van Hecke began his practice in Wisconsin at Lugerville in 1923 as physician for the West Lumber Co. Two years later he moved to Phillips and established his practice, serving that community for the next 35 years. Doctor Van Hecke served in the medical corps during World War I and was active in the American Legion during his lifetime.

He was a member of the Price-Taylor County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Surviving are his widow and one daughter.

Dr. Harry H. Meusel, a practicing physician in Oshkosh for 49 years, died November 10, 1960, at Fond du Lac at the age of 81.

Born December 21, 1878, in Oshkosh, Doctor Meusel was a graduate of Northwestern University Medical School in 1905. He was a veteran of the Spanish-American War. During his years of practice in Oshkosh, he was one of the physicians who established the Oshkosh Clinic and served as a member of the board of education.

Doctor Meusel was a past president of the Winnebago County Medical Society, member of the State Medical Society of Wisconsin, and the American Medical Association. He was a life member of the National Society of Army of the Philippines and a member of the state society's Fifty Year Club.

He retired from active practice in 1956 and moved to Fond du Lac.

Surviving are his widow and one daughter.

Dr. Nicholas J. Knauf, a general practitioner in Chilton, Wis., for 55 years, died November 11, 1960, at the age of 77.

Born October 18, 1883, in Sheboygan, Doctor Knauf was a 1904 graduate of Marquette University School of Medicine. He interned in Superior, began his practice of medicine in Milwaukee and practiced in Forest Junction before going to Chilton in 1905. After postgraduate studies in Europe, he returned to Chilton in 1907 and practiced there until the day before his death.

Doctor Knauf was a member of the Calumet County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He became a member of the state society's Fifty Year Club in 1951 and became a life member in 1956. In 1951 the Chilton Chamber of Commerce named him "Man of the Year," and that same year he was elected chief of the medical staff of St. Elizabeth's Hospital in Appleton.

Survivors include his widow and six sons, three of whom are physicians and surgeons, Dr. James Knauf, Chilton; Dr. John Knauf, Stockbridge; and Dr. Robert E. Knauf, Chilton; and also Dr. Charles Knauf, a dentist, Appleton; Richard Knauf, an attorney, Forest Junction; and Nicholas T. Knauf, a nuclear engineer, Neenah.

Dr. Harold W. Shutter, Milwaukee specialist in obstetrics and gynecology, died November 28, 1960. He was 69 years old.

Born in Carson City, Michigan, on December 27, 1890, Doctor Shutter was a graduate of the University of Michigan Medical School in 1916. He interned at Long Island College Hospital and Johns Hopkins Hospital. From 1917 to 1920 he was a resident at the Long Island hospital. He practiced in Milwaukee for about 40 years. Doctor Shutter served as secretary of the State Board of Medical Examiners in the early 1940's.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association. Doctor Shutter also was a member of the Central Association of Obstetrics and Gynecology, the Wisconsin Society of Obstetrics and Gynecology, the Milwaukee Obstetrical Society, the Chicago Gynecological Society, the Milwaukee Academy of Medicine and the Milwaukee Surgical Society.

He is survived by a son and two daughters.

Dr. Clifton A. Cooper, a general practitioner in Colfax for 37 years, died December 7, 1960, at the age of 84.

Doctor Cooper was born October 5, 1876, in Racine. He was a 1900 graduate of the University of Michigan Medical School. The doctor practiced in Lodi, Montfort, and Norwalk from 1901 to 1917 when he entered the military forces during World War I. Upon his return he established his practice in Colfax where he remained until 1956 when he retired due to ill health.

He was a member of the Eau Claire–Pepin–Dunn County Medical Society, the State Medical Society and American Medical Association until 1957. Doctor Cooper was a member and chairman of the Dunn County Welfare Board from its beginning in 1936 until he resigned in January of 1960. In 1954 he was honored by the Colfax community for his service to the residents.

Surviving are one son and two daughters.

Dr. Paul W. Snowden, a former radiologist at Monroe, died December 12, 1960, in Washington, D. C., at the age of 52.

A graduate of the University of Illinois Medical School in 1942, he interned at Garfield Park Hospital in Chicago and served his residency at Presbyterian Hospital in that city. Doctor Snowden came to Monroe in 1946, leaving in 1959 to become associated with Sibley Memorial Hospital in Washington.

While in Wisconsin he was a member of the Green County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He was also a member of the American College of Radiology, the Radiological Society of North America, the Wisconsin Radiological Society and the American Society of X-ray Technicians. He served as chairman of the Section on Radiology of the State Medical Society.

Dr. Arthur H. Robinson, Jefferson, a general practitioner with a special interest in orthopedic surgery, died December 26, 1960, at the age of 68.

Born in Baraboo, September 9, 1892, he was a 1933 graduate of Marquette University School of Medicine. After internship at Milwaukee County Hospital, Doctor Robinson practiced in Milwaukee until 1937 before moving to Jefferson where he practiced until the time of his death. A veteran of World War I, Doctor Robinson was awarded the Distinguished Service Cross for bravery while serving in the infantry.

Doctor Robinson was a past president of the Jefferson County Medical Society and a member of the State Medical Society and American Medical Association. He served as city health officer in Jefferson.

Surviving are his widow, Marian; and two daughters, Mrs. John O. Batiste, Tehran, Iran, and Mrs. Stewart T. Oliver, Jefferson, Wisconsin.

Dr. Peter Bell, head of correctional psychiatry in the Wisconsin Department of Public Welfare, died January 1, 1961, at the age of 64.

Born December 30, 1896, in Denver, Colorado, Doctor Bell was a graduate of Creighton University School of Medicine, Omaha, Nebraska. Following internship at Mercy Hospital, Council Bluffs, Iowa, he completed residencies at North Shore Hospital, Winnetka, Illinois, and the Neurological Institute, New York City. Doctor Bell was at the Nevada State Hospital, Nevada, Missouri, from 1924 to 1925, and was superintendent of Winnebago State Hospital, Winnebago, Wisconsin, until 1934 when he joined the staff in psychiatric services of the Division of Corrections of the Department of Public Welfare.

Doctor Bell was a member of the Dane County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He was a fellow of the American Psychiatric Association and the American Association of Mental Deficiency and a member of the Milwaukee Neuropsychiatric Society.

Dr. Alfred H. Carthaus, Thiensville general practitioner, died January 2, 1961, at the age of 71. Doctor Carthaus had been retired since 1940.

Born in Plymouth, Wisconsin, March 9, 1889, he was a graduate of the Wisconsin College of Physicians and Surgeons, Milwaukee, in 1911. After internship at St. Joseph's Hospital in Milwaukee, he practiced for three years in that city before going to Thiensville to establish his practice.

He was a village trustee for eight years and village president for 12 years, and also served on the school board. He was president of the Thiensville State Bank since his retirement in 1940.

Surviving are his widow and two daughters.

Dr. George R. Baker, Tomahawk, a general practitioner with a special interest in surgery, died January 9, 1961, at the age of 87.

Born December 27, 1873, in Milwaukee, Doctor Baker was a graduate of Marquette University School of Medicine in 1900. He interned at Trinity Hospital, Milwaukee, and established his practice in Tomahawk the same year, serving that community until his retirement in 1950. Doctor Baker was a veteran of World War I, and was awarded the Purple Heart, Gold Oak Leaf Cluster, and a citation from Gen. John J. Pershing for "exceptionally meritorious and conspicuous service as a surgeon."

A past president of the Lincoln County Medical Society, he was a life member of the State Medical Society and a member of the American Medical Association. He was also named to the state society's Fifty Year Club. Doctor Baker was a member of the State Board of Public Welfare from 1943 to 1949, and served his community as a member of the board of education for 30 years. He was also a member of the Association of Military Surgeons.

Surviving is one son, Dr. Rowe G. Baker, Tomahawk.

SOCIETY RECORDS

NEW MEMBERS

William A. Pruett, M.D., 407 Prospect Street, Beloit, Wisconsin
Paul J. Gilles, M.D., 630 South 10th Street, La-Crosse, Wisconsin
Edward H. Kolner, M.D., 2707 Marshall Court, Madison 5, Wisconsin
James C. Allen, M.D., 1300 University Avenue, Madison, Wisconsin
Richard P. Sabin, 4918 Ascot Lane, Madison
Hermann A. Denzel, Winnebago State Hospital, Winnebago
George W. Arndt, Sr., P. O. Box 270, Neenah
David J. Buran, 59 Racine Street, Menasha.

CHANGES OF ADDRESS

John W. Callahan, M.D., Milwaukee, to 2712 West Center Street, Milwaukee, Wisconsin
James E. Geigler, M.D., Milwaukee, to 5615 West Hampton Avenue, Milwaukee, Wisconsin
John D. Rhodes, M.D., Milwaukee, to 2344 North 116th Street, Milwaukee, Wisconsin
Robert E. Holzgrafe, M.D., Milwaukee, to 1865 West Greenwood, Milwaukee, Wisconsin
Robert A. Schmidt, M.D., Milwaukee, to 6111 West Lisbon Avenue, Milwaukee, Wisconsin
Gerald P. Gredler, M.D., Janesville, to 305 East Court Street, Janesville, Wisconsin
H. F. Beglinger, M.D., Neenah, to 316 Main Street, Neenah, Wisconsin
L. E. Bostain, M.D., Milwaukee, to 612 Hurne Mansur Building, Indianapolis, Indiana
Peter D. O'Loughlin, M.D., Wood, to 8700 West Wisconsin Avenue, Milwaukee, Wisconsin
James H. Habermann, M.D., Mt. Calvary, to 5046 Meade Street, Denver 21, Colorado
P. H. Smith, M.D., Madison to 437 Sippewissett Road, Falmouth, Massachusetts
C. F. Meyer, M.D., Chippewa Falls, to P. O. Box 180, Independence, Missouri
Benjamin A. Ruskin, M.D., Milwaukee, to 2500 North 108th Street, Wauwatosa 13, Wisconsin
John B. Davis, M.D., Markesan, to 2785 Lilly Road, Brookfield, Wisconsin
H. J. Dvorak, M.D., Milwaukee, to UNCAS on Thames Hospital, Norwich, Connecticut
T. J. Pfeffer, M.D., Milwaukee, to 11725 Homewood Avenue, Wauwatosa, Wisconsin
F. R. Muehlhaus, M.D., Milwaukee, to Box 133, Port Washington, Wisconsin
Karl Schlaepfer, M.D., Milwaukee, to % C. J. Nibbi, Privada de la Pradera 55B, Guernavaca, Morelos, Mexico
John J. Van Gilder, M.D., Hortonville, to 1336 North 116th Street, Milwaukee, Wisconsin
Sara G. Geiger, M.D., Milwaukee, to 8700 West Wisconsin Avenue, Milwaukee, Wisconsin
James A. Alston, M.D., Milwaukee, to 210 McCall Street, Waukesha, Wisconsin
Ralph A. Baldzikowski, M.D., Milwaukee, to Indian Hospital, Fort Defiance, Arizona
Manuel M. Aquino M.D., Milwaukee, to 1915 W. Hampton Avenue, Milwaukee, Wisconsin
Robert P. Saicheck, M.D., Milwaukee, to 2301 West Bergen Court, Milwaukee, Wisconsin
J. E. Nilles, M.D., Two Rivers, to Main Street, Mishicot, Wisconsin
G. R. Duer, M.D., Marinette, to 137 Alachua Drive S. E., Winter Haven, Florida
R. L. Mac Cornack, Sr., M.D., Whitehall, to 1626 West Mulberry Street, Phoenix, Arizona
Addie M. Schwittay, M.D., Madison, to Jamaica Family Planning Association, No. 7 Caledima Avenue, Kingston 5, Jamaica, B. W. I.
Albert V. Kanner, M.D., Madison, to 110 East Main Street, Madison, Wisconsin
Thomas E. Bachhuber, M.D., Madison, to 5533 Marsha Drive, Madison, Wisconsin
Blaine W. Claypool, Jr., M.D., Appleton, to 103 West College Street, Appleton, Wisconsin
Donald D. Ewing, M.D., Milwaukee, to 7149 Luana Place, Tucson, Arizona
Robert E. Currie, Los Angeles, to P. O. Box 542, Kenosha
John A. Koepke, Milwaukee, to University of Kentucky Medical Center, Lexington, Kentucky
John J. Brenner, Middleton, to 7256 West 91st Street, Cleveland 30, Ohio
Donald L. Knutson, Milwaukee, to VA Hospital, Greenway Station, Tucson, Arizona
Hans H. Reese, Madison, to University of Alexandria, Alexandria, Egypt
R. C. Parkin, Madison, to VA Central Office, Washington 25, D. C.
Frederick S. Selle, Milwaukee, to 3820 S. Wehr Road, New Berlin
P. H. Smith, Madison, to 5000 Chambers Street, Milwaukee
J. G. Parrish, Texas, to 252 Sheboygan Street, Fond du Lac
Leo Peters, Milwaukee, to 8321 North Greenville Avenue, Fox Point
George F. Flynn, Milwaukee, to 4048 N. Farwell Avenue, Shorewood 11
E. C. Seno, Tomah, to VA Hospital, Downey, Illinois
E. L. Chambers, Madison, to Box 2070, Hartford, Connecticut
Vernon Ward, California, to 4821 Trina Drive, Del City, Oklahoma
Capt. R. E. Fitzgerald, Milwaukee, to Ireland Army Hospital, Fort Knox, Kentucky
Robert E. Wheatley, Madison, to 77 Glenn Road, Brookline, Mass.
Kenneth H. Neldner, Menomonee, to Rochester, Minnesota

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Isuprel Compound Elixir is especially suitable for children, but its pleasant taste will be welcomed by patients of any age.

Each tablespoon (15 cc.) contains:

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Ephedrine sulfate	12 mg.
Theophylline	45 mg.
Potassium iodide	150 mg.
Luminal (brand of phenobarbital)	6 mg.
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Dosage:
Children—from 1 to 3 teaspoons (5 to 15 cc.) three times daily as required. Adults—1 or 2 tablespoons (15 to 30 cc.) three or four times daily as required.

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RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Madison, October 14, 1960.

Name	*School of Graduation*	*Year*	*City*
Andrews, G. R.	Duke Medical School	1948	Wausau
Basso, R. V.	Univ. of Illinois	1933	Richmond, Indiana
Bessire, M. C.	Baylor University	1943	Madison
Blair, A. J., Jr.	Cornell University	1951	Madison
Conley, H. L.	University of Illinois	1959	Wisconsin Dells
Conzelman, D. R.	Woman's Medical College of Pennsylvania	1956	Waukegan, Illinois
Copps, S. C.	University of Colorado	1956	Madison
Currier G. E.	Tufts College of Medicine	1936	Milwaukee
Dammers. W. R.	University of Illinois	1943	Chicago
Evensen, K. L.	University of Colorado	1957	Cleveland
Gilles, P. J.	Creighton University	1959	La Crosse
Graudins, G.	University of Iowa	1956	Rochester, Minnesota
Gutmann, L.	Columbia University	1959	Madison
Howard, H. S.	University of Illinois	1936	Peoria, Illinois
Koenecke, F. H., Jr.	University of Minnesota	1949	Madison
London, L.	Royal College of Physicians and Surgeons—Scotland	1940	Winnebago
Malove, C. H., Jr.	University of Oregon	1946	St. Paul, Minnesota
Newton, M.	University of Vermont	1954	Madison
O'Hearn, J. W.	University of Minnesota	1956	Milwaukee
Plueddeman, P.	University of Illinois	1957	Markesan
Schrader, W. H.	University of Minnesota	1958	St. Paul, Minnesota
Slattery, J. T.	Chicago Medical School	1935	Chicago, Illinois
Stead, W. W.	Emory University School	1943	Wauwatosa
Tegtmeyer, G. F., Jr.	Columbia University	1959	Madison
Van Wormer, D. E.	University of Nebraska	1956	Madison
Vincent, J. H., Jr.	University of Michigan	1957	Madison
Way, T. F.	St. Louis University	1956	Madison
White, W. F.	Oklahoma University	1957	Madison
Williams, J. K.	Louisiana University	1959	Milwaukee
Winston, F.	St. Bartholomew's Hospital Medical College—England	1952	Madison

WISCONSIN STATE DENTAL SOCIETY ANNUAL MEETING

April 24–26 • Milwaukee Auditorium

Wisconsin physicians are invited to attend the annual meeting of the Wisconsin State Dental Society from Monday, April 24, through Wednesday, April 26, at the Milwaukee Auditorium. Registration will be held in the corridor to the left of the Kilbourn Street entrance. Physicians need only to present their 1961 membership card as an identification to obtain a guest badge.

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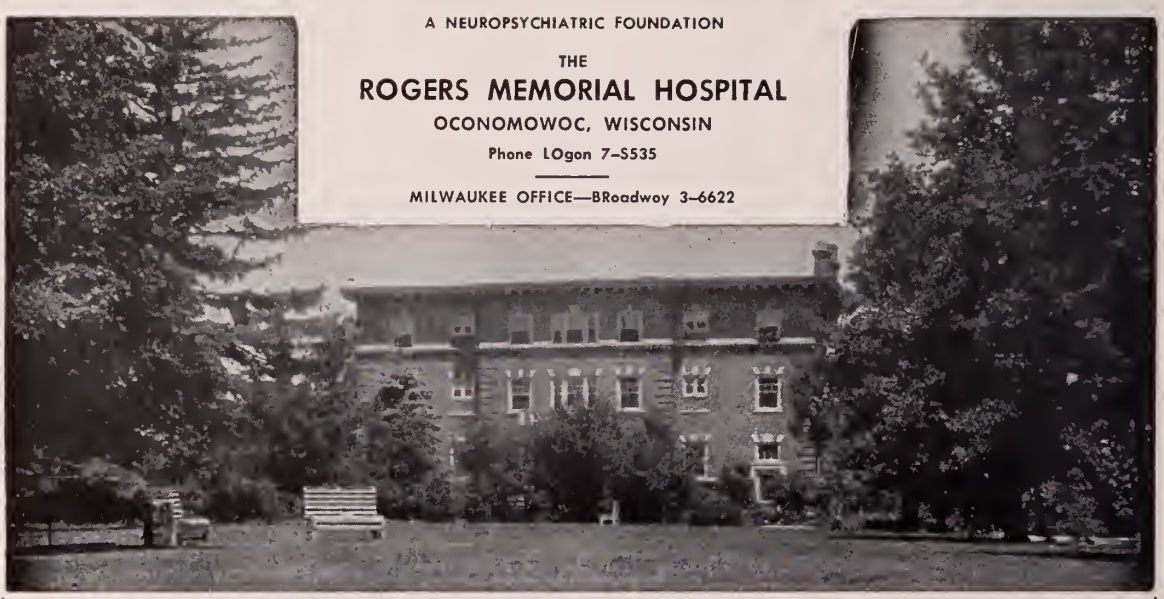

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LOREN J. DRISCOLL, M. D.

JOSEF A. KINDWALL, M. D.
Consultont

LEROY A. WAUCK, Ph. D.
Clinicol Psychologist

The Hospital is situated on the Nashotah Lakes, 30 miles west of Milwaukee, providing the ideal, restful country environment and the facilities for the modern methods of therapy of the psychoneuroses, psychosomatic disorders, alcoholism, and the other neurologic and psychiatric problems. Occupational therapy and recreational activities directed by trained personnel.

NEWS FROM THE MEDICAL SCHOOLS

New Chemotherapy Program at UW

The Department of Pediatrics of the University Hospital has initiated a new chemotherapy program for the treatment of leukemia and other malignant tumors in children. Full-time faculty participation and direction of this program has been established with the appointment of Dr. M. King, pediatric oncologist, to the faculty. Doctor King is a pediatrician and former American Cancer Society fellow at Columbia University College of Physicians and Surgeons. Doctor King will work in the pediatric hematology unit with Dr. Nathan Smith.

The most recently available chemotherapeutic agents are now available for evaluation of their effects on tumors and leukemia. Drugs of proven value in treating these conditions will be used initially in all patients and only in advanced patients, where previously available therapy is no longer effective, are new agents used.

A close working relationship is established between the pediatric chemotherapy unit and the family physician. Certain observation and laboratory follow-up is essential by the family physician while the patient is in his home community. The relationship of the pediatric oncologist and the family physician is, in each instance, one of close and ready communication.

To achieve the goals of this new program, the patients should be seen at the University Hospital as soon as possible after a diagnosis of malignancy is suspected or established. Patients will be accepted into the unit at any stage of their disease, however.

The goals to be accomplished by the program are:

1. Make available the best possible treatment to pediatric patients with malignancy.
2. Gain much needed new information regarding the management of malignancies in early life.
3. Provide the parents the satisfaction of knowing that "everything possible" has been made available to their sick child.
4. To broaden the educational experience at all levels of medical and nursing education at the University.

Questions regarding this program may be addressed by letter or phone to Dr. M. King or Dr. Nathan J. Smith, Department of Pediatrics, University of Wisconsin. ALpine 6-6811.

University Hospitals Experience Increased Occupancy

The 1959–60 fiscal year which ended June 30, 1960, witnessed a steady increase of patients at University Hospitals. The number of admissions to the hospital (14,916) represented an increase of 2.6% over the previous fiscal year and is the highest number of annual admissions since 1955. A total of 196,435 patient days of care were rendered in University Hospitals during the past year. This figure is a 2.9% increase over the previous fiscal year. A total of 97,977 outpatient visits during 1959–60 represented a 9.5% increase. Commenting on these comparative statistics, Mr. Edward J. Connors, Superintendent of the Hospital indicated: "The increased utilization of University Hospitals is an encouraging sign; coupled with the new rate structure which was instituted in January, 1960, this increased occupancy has provided a stabilized financial situation. It is hoped that this will allow the hospital to move ahead on much needed patient care furnishings and equipment."

The remodelling program which was inaugurated by the appropriation of $100,000 during the 1959–60 legislative session is progressing. The architectural firm of John J. Flad and Associates has been selected to plan and design the remodelling of the old units of University Hospitals.

Mr. Connors has also announced the appointment of John Russell as an assistant superintendent of University Hospitals. Mr. Russell has been an assistant at Evanston Hospital, Evanston, Ill., and has now moved to Madison.

$72,000 Grant Received from Kiekhaefer Corp.

The Board of Regents of the University of Wisconsin at the Milwaukee meeting accepted a gift of $72,000 from the Kiekhaefer Corp. of Fond du Lac to continue the Carl Kiekhaefer Professorship in Medicine for a six-year period. Established in 1957 by Mr. E. Carl Kiekhaefer, president of the Kiekhaefer Corp. in honor of his father, the grant provides an annual sum of $12,000 to Dr. David Graham for advance research and education in the medical sciences.

Dr. Seymour Crepea to Live in Arizona

Dr. Seymour Crepea, Associate Professor of Medicine, University of Wisconsin Medical School, Madison, has accepted a position as Medical Director and Research Director of the Sahuare School for Asthmatic Children in Tucson, Arizona. Doctor Crepea, who joined the staff of the Department of Medicine January 1, 1950, and had headed the Allergy Clinic since that time, left Madison in January.

UW Medical Alumni Day

Dr. A. R. Curreri heads the committee in charge of the annual alumni reunion of the University of Wisconsin Medical School on May 19. The program will be held in Service Memorial Institutes followed by a banquet at the East Side Businessmen's Club. Rooms will be reserved for the returning alumni at the Holiday Inn in Madison where the meeting of class representatives and past presidents as well as the meetings of the reunioning classes will be held. The evening program will again include the presentation of an Emeritus Faculty Award and the Medical Alumni Citation.

Marquette School of Medicine Receives Wyeth $5,000 Grant

Dr. Eugene S. Turrell, chairman of the Department of Psychiatry of Marquette University School of Medicine, Milwaukee, on December 13 received an unrestricted grant of $5,000 for medical research from Wyeth Laboratories.

The grant may be applied to any medical research project by the recipient. The Wyeth award to the university is one of twenty made annually by the Philadelphia pharmaceutical manufacturer to further medical research in hospitals and medical colleges throughout the country.

Wide World Photo

Dr. Eugene S. Turrell (left) receives an unrestricted grant of $5,000 from Melvin Ogurak, St. Paul, Minnesota (right), clinical associate of Wyeth Laboratories who made the grant. Looking on is Fred Multoler, Minneapolis, Minnesota, division manager of Wyeth. The Wyeth award is one of 20 made annually by the pharmaceutical manufacturer.

Wisconsin Medical Alumni Met in Milwaukee

One of the world's authorities on the biochemistry of cancer, Dr. Van Potter, spoke on "The Enzyme Deletion Theory of Cancer" at the Milwaukee Winter meeting of the Wisconsin Medical Alumni Association held February 10 at the University Club.

Doctor Potter, a Ph.D. graduate in biochemistry at the University, at present holds the title of Professor of Oncology and Assistant Director of McArdle Laboratory in Madison. He has been associated with the laboratory since its founding in 1940 and during this period has achieved international recognition for his investigations and original concepts on the origin of cancer.

Alumni also heard Dean John Z. Bowers report on Medical School progress and President Mischa Lustok, Milwaukee, and Alumni officers report on Alumni affairs at the evening meeting.

Medical Library Gift

A $3,000 gift from a frequent benefactor of the University of Wisconsin Medical Library, Dr. Maurice L. Richardson of East Lansing, Michigan, was recently received. This gift will enable the Medical Library gradually to incorporate into the Richardson collection the Goldschmid Library of important, color-illustrated works in pathological anatomy, purchased in 1958. Doctor Richardson, a Wisconsin alumnus, has already donated more than 300 works on the history of medicine, valued at more than $15,000 to the Library.

Over one-half of the Goldschmid collection, which is composed of about 250 volumes, were published before 1800. The earliest of these illustrated books are in Latin and the later ones in vernacular tongues. Among the collection is a third edition of Vesalius "Anatomy" and a book by Fallopius. Another book, entitled "Field Book for the Wound Surgeon," was published in 1526.

Postgraduate Course in Milwaukee

The University of Wisconsin Medical School presented a postgraduate course in Neurology entitled "Recent Advances in Diagnosis and Treatment of Neurological Diseases" in Milwaukee Hospital, Milwaukee, February 6 and 7. This course included the present day concepts of treatment of various neurological disorders encountered in the practice of medicine. Epilepsy, vascular disease, and Parkinsonism remain major therapeutic challenges in the neurological field and these were discussed extensively.

Medical School Faculty Activity

Dr. Hans H. Reese, Professor of Neurology, was awarded a Fulbright Foundation Fellowship to lecture on medical science in the areas of neurology and psychiatry and the general field of medicine at the University of Alexandria, Egypt. He left the first part of January. The grant is provided under auspices of the U.S. Department of State, and Doctor Reese will serve as an American Educational Exchange Professor in Egypt. Doctor Reese has done extensive research and study in oncology and in the Tumor Clinic and is well-known for his work with Multiple Sclerosis.

Dr. James A. Miller, Professor of Oncology, left December 9 for Geneva, Switzerland, to attend an Expert Committee on Food Additives of Food and Agricultural Organization and World Health Organization. Representatives from many countries will discuss the problem of food additives on a world-wide basis.

SMS ANNUAL MEETING
MAY 2–3–4, 1961
See program on pages 165–169

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Facts about

WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON MEDICAL CARE PLANS

COVERAGE FOR DIAGNOSTIC SERVICES

Physicians and their medical assistants may find it helpful to review this brief discussion of coverage available to WPS subscribers whose contracts provide for diagnostic benefits.

Proper reporting of these claims for diagnostic benefits will speed up the processing of the claims and improve WPS services to the satisfaction of both subscribers and physicians.

The determination of which diagnostic benefits are payable rests heavily on the information provided in the Physician's Service Report.

The services of the WPS medical consultant are utilized in the review of all claims in which medical advice is required. His particular interest with respect to diagnostic procedures is in decidng, upon the basis of information submitted, which of such procedures are related to or associated with the illness or complaint.

The coverage provided for diagnostic services in the outpatient department of a hospital or in a doctor's office does not contemplate benefits for normal physical examinations, check-ups, or re-checks (including endoscopics). Diagnostic services rendered to a bed patient in a hospital must be directly related to the patient's illness or complaint if benefits are to be provided.

Optional procedures primarily or essentially simply part of or in whole a health examination, are not paid.

Without sufficient information relating the diagnostic services to the patient's complaint or complaints, WPS will be unable to provide payment for these services.

When completing the Physician's Service Report, please indicate as specifically as possible the nature of the illness or complaint for which diagnostic procedures were employed.

In addition you may wish to advise your patients that although they may not hold a WPS contract for procedure benefits for purely diagnostic services, WPS offers riders at reasonable additional cost which are designed to provide this coverage.

WPS SURGICAL MEDICAL HOSPITAL

WISCONSIN PHYSICIANS SERVICE

THE DOCTORS' PLAN OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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MEDICAL MEETINGS—POSTGRADUATE COURSES

Minnesota Medical Continuation Courses

The following will be presented at the Center for Continuation Study, University of Minnesota:

Feb. 27–Mar. 1: Pediatrics for General Physicians and Specialists
Mar. 13–15: Allergy for General Physicians and Specialists
Mar. 17–18: Trauma for General Physicians
Apr. 17–19: Internal Medicine for Internists
Apr. 20–22: Otolaryngology for General Physicians
May 1–3: Ophthalmology for Specialists
May 8–10: Gynecology for General Physicians
May 11–13: Surgery for Surgeons
May 15–19: Proctology for General Physicians
June 1–13: Office Psychotherapy for General Physicians
1961–All Year: Cancer Detection for General Physicians

For further information concerning the above courses, write to the Director, Department of Continuation Medical Education, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14.

Chicago Ophthalmology Society Meeting

The Chicago Ophthalmological Society announces the preliminary program of the annual Clinical Conference to be held on May 19 and 20, at the Drake Hotel in Chicago, Illinois.

The guest speakers will include Count H. Arruga, Barcelona, Spain, Mr. G. Leigh, London, England, Dr. Bernard Becker, St. Louis, Mo., Dr. Harold G. Scheie, Philadelphia, Pa., and Dr. Robert N. Shaffer, San Francisco, California.

The subjects will include a symposium on surgery and medical therapy of narrow and open angle glaucoma; retinal detachment; a symposium on secondary glaucoma; and corneal surgery. Other subjects to be announced later.

Registration fee for the entire course including round table luncheons and dinner is $45.00 and may be payable to the Registrar: Mrs. Mary E. Ryan, 1150 North Lorel Avenue, Chicago 51, Illinois.

The Seventeenth Annual Gifford Memorial Lecture will be delivered by Dr. Harold G. Scheie of Philadelphia, Pa., on Friday, May 19, at the Drake Hotel at 5:15 P.M. All physicians are invited to attend the Gifford Memorial Lecture and dinner which follows.

Courses on Fractures and Other Trauma

The Fifth Postgraduate Course on Fractures and Other Trauma sponsored by the Chicago Committee on Trauma of the American College of Surgeons will be held April 19, 20, 21, and 22 at the John B. Murphy Memorial Auditorium, 50 East Erie Street, Chicago.

The course for 1961 is dedicated to Dr. Edwin Ryerson, an eminent orthopedic surgeon who was a leader in his field and for many years was actively associated with the Chicago Committee on Trauma of the American College of Surgeons.

The three and one-half day Course will be presented by a distinguished faculty of eleven guest speakers and teachers prominent in the fields of trauma from the five medical schools and chiefs of services from leading Chicago hospitals who will discuss all phases of trauma; injuries to the head, face, chest, abdomen; genitourinary tract; plastic procedures of the extremities; skeletal traction versus adhesive traction; shock; the current prevention and treatment of gas gangrene; blood vessel injuries; major tendon disruptions; acute tendon injuries of the hand and forearm; ligamentous injuries to the knee; modern amputation techniques; a new treatment for suppurative conditions secondary to trauma of the skeleton.

There will be panel discussions on athletic injuries and fractures and dislocations of the tarsal bones. Many types of fractures and dislocations will be discussed.

Distinguished visiting speakers will be Doctors William H. Bickel, Rochester, Minn.; Bruce J. Brewer, Milwaukee; James Barrett Brown, St. Louis; Edwin F. Cave, Boston; C. Howard Hatcher, Palo Alto; Charles C. Higgins, Cleveland; J. William Littler, New York; Owen E. Miller, Milwaukee; Austin T. Moore, Columbia, S.C.; Don H. O'Donoghue, Oklahoma City; and Robert A. Robinson, Baltimore.

Dr. Sam W. Banks, Chairman of the Chicago Committee on Trauma, is Director of the Course. Inquiries should be addressed to Dr. John J. Fahey, who is Chairman of the Committee on the Postgraduate Course on Fractures and Other Trauma. Registration fee will be $75.00.

Wisconsin Anti-Tuberculosis Association

The 53rd annual meeting of the Wisconsin Anti-Tuberculosis Association will be held April 13 and 14 at the Hotel Schroeder, Milwaukee.

Surgery of Hand at New York

A five-day full-time course on Surgery of the Hand will be offered by the New York University Medical Center from March 6–11, under the direction of William T. Medl, FACS, and Thomas D. Rees, FACS. The course is designed mainly for general, orthopedic, plastic and industrial surgeons.

The class is limited to 40 participants and the tuition is $125. For applications communicate with the office of the Associate Dean, New York University Post-Graduate Medical School, 550 First Avenue, New York 16, N.Y.

Marquette University School of Medicine

in cooperation with the Milwaukee County Hospital

PRESENTS A POSTGRADUATE COURSE

on

GASTROENTEROLOGY

TIME Wednesday Mornings, 9 to 12; April 5, 12, 19 and 26, 1961

PLACE Milwaukee County Hospital, Fifth Floor Conference Room

DIRECTOR Michael W. Shutkin, M.D., Associate Clinical Professor of Medicine, Marquette University School of Medicine.

PROGRAM

1st Session: April 5, 1961

9:00 The Physiology of Digestion—Robert E. Yunck, M.D.
9:30 Genetics in Gastroenterology—Donald Greiff, Sc.D.
10:00 Applied Psychiatry in Gastroenterology—Eugene S. Turrell, M.D.
10:30 Gastrointestinal Radiology—John R. Amberg, M.D.
11:00 Role of Radioisotopes in the Diagnosis of Gastrointestinal Disease—Norman H. Engbring, M.D.
11:30 Endocrinopathies in Gastroenterology—William W. Engstrom, M.D.

2nd Session: April 12, 1961

9:00 Bilirubin Metabolism—M. C. F. Lindert, M.D.
9:30 Clinical Significance of Hepatic Enzymes—Irvin M. Becker, M.D.
10:00 Diagnosis and Treatment of Granulomatous Disease of the Liver—Burton A. Waisbren, M.D.
10:30 Portal Hypertension—Jack J. Levin, M.D.
11:00 Electrolytes and Diuretic Therapy in Liver Disease—Ben I. Heller, M.D.
11:30 The Gastrointestinal Manifestations of Pulmonary Disease—William W. Stead, M.D.

3rd Session: April 19, 1961

9:00 Cyto-diagnosis in Gastrointestinal Malignancy—Edward S. Levy, M.D.
9:30 Ulcerogenic Tumors of the Pancreas—Edwin H. Ellison, M.D.
10:00 Gastrointestinal Lymphoma—Anthony V. Pisciotta, M.D.
10:30 Chemotherapy in Gastrointestinal Carcinoma—John D. Hurley, M.D.
11:00 The Differential Diagnosis of Malabsorptive States—Willard A. Krehl, Ph.D., M.D.
11:30 Diagnosis and Management of Upper G. I. Bleeding—Joseph Shaiken, M.D.

4th Session: April 26, 1961

9:00 Collagen Disorders in Gastroenterology—Philip B. O'Neill, M.D.
9:30 The Modern Treatment of Intestinal Parasites—Harry J. Kanin, M.D.
10:00 The Irritable Colon Syndrome—Michael W. Shutkin, M.D.
10:30 The Gastrointestinal Manifestations of Cardiac Disease—John H. Huston, M.D.
11:00 The Late Post-surgical Problems of Gastrectomy—Edwin H. Ellison, M.D.
11:30 Diagnosis and Treatment of Ano-rectal Disease—Robert T. McCarty, M.D.

THE COURSE WILL BE LIMITED TO 100 PHYSICIANS

CREDIT 12 Hours, Category 1, American Academy of General Practice

TUITION FEE $30. Make checks payable to Marquette University School of Medicine

RESERVATIONS Send to: JOSEPH W. RASTETTER, M.D.
Director of Postgraduate Medical Education
Marquette University School of Medicine
8700 West Wisconsin Avenue
Milwaukee 13, Wisconsin

NAME & ADDRESS _____

_____

_____

WISCONSIN CALENDAR COMING EVENTS

1961

Feb. 25–26: SMS Council Meeting, Madison.

Feb. 28: Meeting, Milwaukee Oto-Opthalmic Society, Univ. Club, Milwaukee.

Mar. 2, 9, 16, 23: Postgraduate course, Current Problems in Internal Medicine, Marquette U. Sch. of Med., Milwaukee.

Mar. 22: Presidents and Secretaries of County Medical Societies, meeting at SMS headquarters, Madison.

Mar. 28: Meeting, Milwaukee Oto-Ophthalmic Society, Univ. Club, Milwaukee.

Apr. 5, 12, 19, 26: Postgraduate course, Gastroenterology, Marquette U. Sch. of Med., Milwaukee.

Apr. 13–14: Annual meeting, Wisconsin Anti-Tuberculosis Association, Hotel Schroeder, Milwaukee.

Apr. 13–15: Hematologic Disorders in Pediatrics, UW postgraduate course, Wisconsin Center Building, Madison.

Apr. 16 Central regional meeting, American College of Gastroenterology, Milwaukee.

Apr. 24–26: Wisconsin State Dental Society annual meeting, Milwaukee.

Apr. 25: Meeting, Milwaukee Oto-Ophthalmic Society, Univ. Club, Milwaukee.

Apr. 30: Opening of Museum of Medical Progress, Prairie du Chien.

May 2–3–4: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 11–13: Pathology and Radiology of Chest Diseases, UW postgraduate course, Wisconsin Center Building, Madison.

May 20–21: Wisconsin Association of Blood Banks, meeting, Conway Hotel, Appleton.

May 23: Annual social meeting, Milwaukee Oto-Ophthalmic Society, Univ. Club, Milwaukee.

June 26–30: AMA Annual Meeting, New York, New York.

Aug. 29–31: UW Postgraduate course, Psychiatric symposium, Dr. R. Roessler, chrm., Wisconsin Center Building, Madison.

Sept. 28–30: UW postgraduate course, Anesthesiology, Dr. O. S. Orth, chrm., University Hospitals, Madison.

Oct. 13–14: UW postgraduate course, Psychiatry, Dr. R. Roessler, chrm., Wisconsin Center Building, Madison.

Nov. 16–18: UW postgraduate course, Rehabilitation of Patients with Injuries of the Spinal Cord, Dr. A. Siebens, chrm., Wisconsin Center Building, Madison.

Nov. 28–Dec. 1: AMA Clinical Meeting, Denver, Colorado.

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

Intensive Postgraduate Courses

STARTING DATES—WINTER–SPRING, 1961

Surgical Technic, Two Weeks, April 17
Surgery of Colon & Rectum, One Week, March 6
Gallbladder Surgery, Three Days, April 17
Surgery of Hernia, Three Days, April 20
General Pediatrics, Two Weeks, May 1
Electrocardiography & Heart Disease, One Week, April 17
Diagnostic Radiology, Two Weeks, April 3
Board of Surgery Review, Part II, Two Weeks, March 6
Gynecology, Office & Operative, Two Weeks, April 10
Vaginal Approach to Pelvic Surgery, One Week, March 27
Obstetrics, General & Surgical, Two Weeks, March 13
Fractures & Traumatic Surgery, Two Weeks, March 6
Practical Cystoscopy, Ten Days, by appointment
Surgery of the Hand, One Week, April 17
Advances in Medicine, One Week, March 13
Urology, Two Weeks, April 17

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Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

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Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

VOL. 60, NO. 3—MARCH 1961

STATE MEDICAL SOCIETY OF WISCONSIN — MEDICINA NUSQUAM NON EST

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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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HELP FOR UNMARRIED MOTHERS

Dear Doctor:

From a discussion with the Wisconsin Medical Society, we understand that you are interested in securing some information concerning the resources you might use in advising an unmarried woman, who is pregnant out of wedlock, in planning for herself and her child. We are enclosing a brochure, HELP FOR UNMARRIED MOTHERS, which we believe will be of interest to you. We are also discussing the services available through agencies and certain laws which you may find helpful in relation to providing medical care to an unmarried mother.

Counseling Service: We suggest that you refer any girl or woman pregnant out of wedlock to the County Department of Public Welfare of the county of which she is a resident, if her permanent residence is in Wisconsin. If her permanent residence is not in Wisconsin, or if she does not want to contact her county of residence, she should be referred to the County Department of Public Welfare, or to the District Office, Division for Children and Youth.

If, for any reason, you or your client prefer to contact the Division for Children and Youth District Office, this is acceptable and we urge you to not hesitate in making this contact. Any agency providing services to unmarried mothers will be able to counsel with her in regard to her personal problems and planning for herself and her child and will be able to assist her in securing appropriate living arrangements, financial assistance, if needed, legal advice, and other counseling such as spiritual counseling if she wishes to use this.

Living Arrangements: A variety of living arrangements, such as boarding home care, work home care, or maternity hospital care are usually available and can be arranged through the agency. If the mother is a minor, the boarding or work home in which she is living must be licensed. These homes, by legal definition, are foster homes and there is a prohibition against anyone placing a child in foster care except agencies authorized to do so.

Financial Assistance: Arrangements for securing financial assistance for the mother for her maintenance, medical and hospital care, and care for the baby can be arranged through an agency when indicated. A variety of funds are available so that there should never be any reason for an unmarried mother to have to make an arrangement to place her child for adoption with a specific family in exchange for payment for her maintenance, medical and hospital care.

Planning for the Baby: If the mother wishes to release her child for adoption, our District Offices or the voluntary agencies listed in the enclosed brochure would be able to select a home especially for the child and assure the mother that they will accept the child directly from the hospital. They will also assist her in making the arrangements for the necessary legal procedures so that the mother's rights are terminated and the child freed for adoption. The agencies will select a home especially chosen for the child and will be able to assure the mother that the child's needs are being met.

In regard to the placement of the child, we would also like to call to your attention that there is a definite prohibition against anyone, except an agency licensed or authorized to do so, assisting a mother in negotiating or arranging for a placement. This prohibition specifically states:

> **48.63. Restrictions on independent placement.** (1) No person, except the child's parent or guardian or the department, a county agency performing child welfare services under s. 48.56 (1), a child welfare agency licensed to place children in foster homes, or a court of record, may:
>
> (a) Place a child or negotiate or act as intermediary for the placement of a child in a foster home; or
>
> (b) Offer or hold himself out as able to place a child in a foster home.

We hope this information will be helpful to you in directing your clients to whom this information might apply to the appropriate agency. If you have any questions about this, please do not hesitate to write us or contact the District Office.

(Miss) Dorothy I. Waite
Director
Division for Children and Youth
Wisconsin State Department
of Public Welfare

SMS ANNUAL MEETING
May 2, 3 and 4, 1961
Milwaukee

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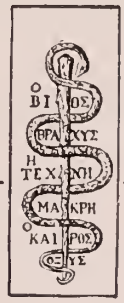

A $5,000 BEQUEST TO STUDENT LOAN FUND

Helping other people was an important part of the life of Florence A. Duckering, M.D., of Sheboygan, who passed away January 21.

This deep regard for helping others was revealed in her Last Will and Testament. Among numerous bequests to organizations dedicated to this principle was $5,000 to be placed in the Student Loan Fund of the Foundation.

Doctor Duckering
Rogers Crocker Studio Photo

Each time the funds are loaned to a medical student, repaid, and then placed on loan again, the empathy which Doctor Duckering felt for others will be renewed.

During a trip to the Far East last June, Doctor Duckering was impressed by the charitable work of the American Friend Service Committee, operated by the Quaker faith. A large share of her estate will go to support the work of this organization. Other beneficiaries are the American Board of Commissioners for Foreign Missions and the Boston Guild of Hard of Hearing.

In an account of her death, *The Sheboygan Press* said, "Florence Duckering's life reflected her profession to a high degree. At the foundation of her success was her gentleness, kindliness, sympathetic understanding and her meticulous attention to both the physical and emotional needs of those in her care."

As a result of her bequests, many will remain "in her care" for years to come.

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COUNTY SOCIETY PROCEEDINGS

BROWN

About 70 members of the Brown County Medical Society heard *Dr. E. D. Sorenson*, Elkhorn, president of the State Medical Society, discuss current topics of interest to the medical profession at the society's January 12 meeting in Green Bay. Among the many topics covered by Doctor Sorenson was the Kerr-Mills law concerning medical care for the aged.

Dr. Milton Feig, Madison, State Board of Health, addressed the society on the function and benefits of the x-ray mobile unit. A discussion of the county society's emergency call system was held and recommendations regarding its future operation were made by *Dr. R. M. Waldkirch*, De Pere, chairman of the Hospital Relations Committee.

BARRON–WASHBURN–SAWYER–BURNETT

Dr. Robert Samp, of the University of Wisconsin Medical School, was the speaker at the January 10 meeting of the Barron-Washburn-Sawyer-Burnett County Medical Society. His topic was "Cancer Examinations." Also on the program was Mr. Lawrence Ryder, of Wisconsin Physicians Service, who discussed health insurance plans. During the business session discussion was held on the mental health clinic which will open July 1 for Barron and Polk counties. Seventeen members were present.

At the February meeting, held at Rice Lake, Charles Johnson, field representative for the American Medical Association, talked on "Medical Legislation."

During the business session it was decided to invite *Dr. Ralph Frank*, Eau Claire, district councilor, and Congressman Lester Johnson to speak at future meetings. *Dr. C. J. Strang*, Barron, was elected CES Foundation Trustee and *Dr. D. G. Macmillan*, Barron, reported on the mental health clinic for Barron and Polk counties.

CALUMET

Dr. James W. Knauf, Chilton, was elected president of the Calumet County Medical Society at the January 17 meeting in Hilbert. *Dr. Francis P. Larme*, New Holstein, was named vice-president, and *Dr. Rafael Barajas*, Brillion, was elected secretary. Named representative to the Charitable, Educational and Scientific Foundation of the State Medical Society was *Dr. Everett W. Humke*, Chilton. Nine members attended the meeting.

CLARK

Members of the Clark County Medical Society elected *Dr. Sarah Rosekrans*, Neillsville, president at their January 18 meeting in Neillsville. *Dr. Kenneth F. Manz*, Neillsville, was reelected secretary; *Dr. M. V. Overman*, Neillsville, was named delegate and *Dr. R. L. Hansen*, Colby, alternate to the House of Delegates.

DANE

Dr. Harry F. Dowling, professor of medicine and head of the department at the University of Illinois College of Medicine, was main speaker at the February 14 meeting of the Dane County Medical Society.

The board of trustees of the society reaffirmed its plan for immunization of all residents in the community against polio, using Salk vaccine, since oral vaccine is unavailable.

DOUGLAS

The Douglas County Medical Society entertained the auxiliary members at its annual Ladies Night Banquet held at Cronstrom's Supper Club in Superior in December.

JEFFERSON

At the January meeting the members heard *Dr. G. A. Kerrigan*, associate professor of pediatrics at the Marquette University School of Medicine, discuss "Thyroid Disorders In Childhood." *Dr. H. G. Mallow*, Fort Atkinson, gave a report of the meeting of the House of Delegates in May, 1960. In elections, *Dr. E. P. Schuh*, Watertown, was named to a three-year term on the Committee on Public Health, *Dr. H. W. Aufderhaar*, Fort Atkinson, to a two-year term, and *Dr. John S. Garman*, Waterloo, to a one-year term. *Doctors F. A. Wendt*, Johnson Creek, *J. H. Russell*, Fort Atkinson, and *C. G. Maloney*, Fort Atkinson, were appointed to the Auditing Committee. Twenty members were present at the meeting.

LA CROSSE

Seventy-one members of the La Crosse County Medical Society heard Dr. Nathan Smith, professor and chairman of the department of pediatrics, University of Wisconsin Medical School, discuss "Hemoglobin and the Causes of Anemia" at a January 16 meeting in La Crosse.

During the business session the committee appointments for the new year were announced, a proposal to continue the county immunization program was accepted, and official excuse blanks for physical education classes were reviewed and accepted.

LINCOLN

Dr. H. G. Adams, Tomahawk, was elected president of the Lincoln County Medical Society at a December 13 meeting held at Merrill. *Dr. E. C. Jarvis*,

———

Physicians whose names appear in italic are members of the Society.

Tomahawk, was named vice-president and *Dr. E. O. Ravn, Jr.*, Merrill, secretary-treasurer. *Dr. James Bigalow*, Merrill, was named delegate and *Dr. K. M. Morris*, Merrill, alternate to the House of Delegates.

Speakers for the evening were *Dr. R. S. Baldwin* and *Dr. R. J. Rowe*, both of Marshfield.

MARATHON

Dr. Roy B. Larsen, Wausau, was installed as president of the Marathon County Medical Society at the December meeting held in Wausau. He succeeds *Dr. R. C. Shannon*, Wausau. Named president-elect was *Dr. Orville Kelley*, while *Dr. T. C. Burr, Jr.*, was re-elected secretary-treasurer. Both are from Wausau.

ONEIDA-VILAS

County Judge George Richards of Rhinelander spoke before the January 18 meeting of the Oneida-Vilas County Medical Society on referral of patients to state medical institutions and related medicolegal problems.

Elected president of the society for the coming year is *Dr. Frances A. Cline*, Rhinelander. *Dr. Allen Johnson*, Rhinelander, was named vice-president, *Dr. Warren K. Simmons*, Rhinelander, secretary-treasurer, and also delegate to the State Medical Society, while *Dr. Lewis W. Jacobson*, Eagle River, was named alternate. Fourteen members were present.

PIERCE–ST. CROIX

The Pierce-St. Croix County Medical Society met February 21 for dinner and a program at the home of *Dr. A. W. Limberg*, Glenwood City.

PORTAGE

Members of the Portage County Medical Society heard *Dr. Ralph E. Campbell*, professor of obstetrics and gynecology at the University of Wisconsin Medical School, talk on cancer at their December 8 meeting in Stevens Point. Doctor Campbell's appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society.

At their January meeting the society members heard *Dr. O. O. Meyer*, professor and chairman of the department of surgery at the University of Wisconsin Medical School talk on "Recent Advances in Therapy." His appearance was also sponsored by the Foundation.

POLK

Dr. Albert Stoesser, St. Paul, Minnesota, spoke on "Allergy in Children" at the January 19 meeting of the Polk County Medical Society held at Balsam Lake. During the business meeting *Dr. Michael Marra*, Amery, was elected secretary-treasurer to replace *Dr. Lewis J. Weller* of Osceola, who resigned.

RACINE

Dr. Joseph D. Postorino, Racine, was installed as president of the Racine County Medical Society at a meeting December 6 at the Racine Country Club. Also installed were: president-elect, *Dr. F. M. Hilpert*, Racine; vice-president, *Dr. Warren Williamson*, Racine; secretary, *Dr. E. L. MacVicar, Jr.*, Racine; and treasurer, *Dr. Leslie Jones*, Racine.

SAUK

At the February 14 meeting in Baraboo, the members heard *Dr. Anthony Curreri*, University of Wisconsin Medical School, discuss "Treatment of Massive Gastrointestinal Hemorrhaging."

TREMPEALEAU–JACKSON–BUFFALO

Dr. William Wright, Mondovi, has been installed as president of the Trempealeau-Jackson-Buffalo County Medical Society for 1961. Elected for the coming year at the annual meeting were *Dr. Roland Thurow*, Black River Falls, president-elect; *Dr. John Noble*, Black River Falls, secretary-treasurer; *Dr. Elmer Rohde*, Galesville, delegate; Doctor Wright, alternate; and *Dr. O. M. Schneider*, Blair, public relations officer.

WOOD

Dr. D. A. Emanuel, Marshfield, spoke before the Wood County Medical Society February 2 on "Farmer's Lung." The meeting was held in Marshfield, with 43 members present.

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Milwaukee Academy of Medicine

Members of the Milwaukee Academy of Medicine heard Dr. John H. Talbott, editor, Journal of the American Medical Association, talk on "Medicine and Medical Communication" at their January 17 meeting at the University Club of Milwaukee.

At the February meeting academy members heard *Dr. Francis M. Forster,* professor and chairman, Department of Neurology, University of Wisconsin Medical School, discuss "Trends in the Treatment of Epilepsy." Members of the Milwaukee Neuropsychiatric Society were invited to attend the presentation which was the Arthur Wilson Rogers Memorial Lecture.

At the March 21 meeting, held at the University Club, members heard Theodore T. Puck, Ph.D., speak on "Studies on the Mammalian Cell and Some of its Clinical Applications." Doctor Puck is Professor and Head, Department of Biophysics, University of Colorado, Department of Medicine.

Milwaukee Neuropsychiatric Society

Dr. Seymour Halleck, Madison, chief psychiatrist of the Wisconsin Division of Corrections, spoke before the Milwaukee Neuropsychiatric Society January 18 at the University Club.

Physicians whose names appear in italic are members of the Society.

Doctor Halleck said the power of the psychiatrist under the sex crime law "frightens me to death sometimes." He said the law under which the psychiatrist's recommendation usually determines disposition of the case puts a tremendous social responsibility on psychiatrists. Despite shortcomings in the law, its value has been amply proved, the doctor stated. He cited statistics over a 10-year period to support his statement.

Members of the Milwaukee Neuropsychiatric Society met March 15 at the University Club of Milwaukee for a business meeting, dinner and a scientific program. A panel discussion was held on "The Psychotic Child." The panel consisted of *Drs. Bernhard Kaufman,* Milwaukee; *Harold Borenz,* Madison; *Robert O'Connor,* Milwaukee; and *Leonard Ganser,* Madison.

Milwaukee Oto-Ophthalmic Society

Members of the Milwaukee Oto-Ophthalmic Society met February 28 at the University Club of Milwaukee for dinner and a scientific program.

Dr. David W. Kersting, Professor and Chairman of Dermatology at Marquette University School of Medicine, discussed the subject, "Dermatologic Aspects of Diseases of the Eye, Ear, Nose and Throat."

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NEWS OF WISCONSIN PHYSICIANS

Dr. Braswell Ends Practice At Owen

Dr. H. M. Braswell, Jr., who has practiced medicine in Owen since 1956, has announced that he intends to give up his practice within the next six months and move to either Arkansas or Louisiana. He has indicated he will remain in Owen until another physician arrives to replace him.

New Physician At Dousman

Dr. Thomas G. Haugh, Oconomowoc, opened his practice in Dousman early in January. A graduate of Marquette University School of Medicine, he interned at Misericordia Hospital in Milwaukee and then spent four years with the Air Force. Before opening his Dousman office, Doctor Haugh was associated with the Wilkinson Clinic, Oconomowoc.

Dr. Caffrey Opens Green Bay Practice

Dr. James F. Caffrey joined *Dr. Charles A. Wunsch* in the practice of psychiatry at Green Bay on December 1. A graduate of Marquette University School of Medicine, Doctor Caffrey interned at Milwaukee County General Hospital. He has served as assistant medical director of Rogers Memorial Hospital, Oconomowoc, as psychiatric resident at Warren State Hospital in Pennsylvania, and was director of professional education at Logansport State Hospital, Indiana.

Doctor Samp Speaks At Stevens Point

Dr. Robert J. Samp, medical director of the Wisconsin Division of the American Cancer Society, was the main speaker at the annual "Distinguished Citizen" award dinner in Stevens Point January 17.

Doctor Moore Named "Man Of The Year"

Dr. Lewis A. Moore, 85, has been selected as the "outstanding man of the year" in Monroe by the Junior Chamber of Commerce. Doctor Moore has practiced medicine in the community since 1907. He is also city health officer.

Physicians On Elm Grove Health Panel

Dr. John W. Harkness, Wauwatosa, and *Dr. John O. Grade*, Elm Grove, were members of a panel which discussed practices and principles deemed most vital in promoting the health of primary school children at the January meeting of the St. Mary's Home and School Association in Elm Grove. Doctor Harkness spoke on pediatrics and Doctor Grade gave the view of the general practitioner.

Physicians whose names appear in italic are members of the Society.

Doctor Gilles Practices In La Crosse

Dr. Paul J. Gilles, a graduate of Creighton University School of Medicine in Omaha, Nebraska, has joined Doctors *Simones, Gallagher* and *Doyle* in medical practice in La Crosse. Doctor Gilles interned at Ancker Hospital in St. Paul, Minnesota.

Doctor Pavlic Addresses Gynecological Society

Dr. Robert S. Pavlic, Brookfield, presented a paper entitled "The Incompetent Cervix: Its Diagnosis and Treatment" before the Chicago Gynecological Society on December 23. The meeting was attended by about 200 physicians from the Chicago and Milwaukee areas.

Doctor Andre Leaves Oak Creek

Dr. C. E. Andre, Oak Creek, has closed his clinic in that community and intends to return to his native state, Ohio, to set up his practice. Doctor Andre was the only physician practicing in Oak Creek.

Dr. Quandt Named Jefferson Health Officer

Dr. Courtney Quandt was named health officer of the city of Jefferson January 3. The appointment was made by Jefferson mayor, Robert C. Hearne. Doctor Quandt will fill the unexpired term of the late Dr. A. H. Robinson.

Doctor Cooper Practices In Janesville

Dr. Thomas H. Cooper, a dermatologist, is now associated with the Janesville Medical Center. A graduate of the Marquette University School of Medicine, he was formerly with The Monroe Clinic in Monroe.

Doctor Winston Opens Madison Practice

Dr. Frank Winston, formerly of Lincoln, Nebraska, has opened a psychiatric practice in Madison in association with *Dr. Bryant Roisum*. Born in England, Doctor Winston received his medical training at the University of London Medical School. He received psychiatric training at London and Leeds in England and Johannesburg in South Africa. He completed his American residency at the Nebraska Psychiatric Institute in Omaha, Nebraska, and was associated with the Nebraska State Hospital in Lincoln before coming to Madison.

Dr. Haines Chairman Of Blood Donor Club

Dr. B. J. Haines, Cadott, was re-elected chairman of the Chippewa County Blood Donor Club at the annual meeting of the group in December.

Doctor Tenney Speaks At Fort Atkinson

Dr. H. Kent Tenney, Madison, spoke December 12 in Fort Atkinson on "The Disturbed Child." The program was sponsored by the local chapter of the American Association of University Women.

Doctor Freeman Speaks On Heart Disease

Dr. D. J. Freeman, chairman of the Marathon County Heart Council, spoke on heart diseases at a meeting of the Wausau Optimists Club in December. He outlined the work of the Heart Council in research on cardiovascular diseases, community service, and dissemination of research results to physicians and the public.

Doctor Sabin Opens Madison Office

Dr. Richard P. Sabin has opened an office in Madison for the practice of psychiatry. A graduate of the University of Wisconsin Medical School, he interned at Good Samaritan Hospital in Portland, Oregon, and completed his residency at the University of Wisconsin. Doctor Sabin was an Air Force medical officer from 1957 to 1959. He will also be associated with the University Hospitals Department of Psychiatry in Madison.

Doctor Berg Receives Certification

Dr. Mary C. Berg, Madison, has been certified by the American Board of Psychiatry. She is a graduate of the University of Wisconsin Medical School and received psychiatric training at the universities of Wisconsin and Pennsylvania and at Mendota State Hospital. She has been in private practice in Madison and also serves as consulting psychiatrist at Mendota and has been an instructor in clinical psychiatry at the university medical school.

Dr. Crow Addresses Midyear Convocation

Dr. James F. Crow, professor of medical genetics and zoology at the University of Wisconsin Medical School, presented the address at the convocation honoring midyear graduates of the university on January 7.

Marathon Honors Doctor Kampine

Dr. and Mrs. *Clifford Kampine* were honored in December at a community-wide testimonial in Marathon. The occasion was Doctor Kampine's 25th anniversary of service to the Marathon area. A program was held in St. Mary's School auditorium.

Dr. Ris Speaks On Television And Children

Dr. Hania Ris, pediatrician and clinical instructor at the University of Wisconsin Medical School, spoke on "Television and Children" before the Madison Council for Better Broadcasts in January.

Doctor Rosandich Joins Osceola Clinic

Dr. Ronald Rosandich, a 1959 graduate of the University of Wisconsin Medical School, is now associated with the Osceola Clinic. Doctor Rosandich interned at St. Francis Hospital in Wichita, Kansas, and was in residency training at the Veterans Administration Hospital in Wichita.

Doctor Beck Appointed Waushara Coroner

Dr. A. A. Beck, Wautoma, has been appointed Waushara County Coroner by Governor Gaylord Nelson. He succeeds *Dr. R. C. Darby*, who resigned recently.

Dr. McCormick A Diplomate in Pathology

Dr. Raymond A. McCormick, Green Bay, has been named a diplomate with the American Board of Pathology. A graduate of the Marquette University School of Medicine, Doctor McCormick received his specialty training at that school and at St. Mary's Hospital in Milwaukee. He is presently assistant pathologist at St. Vincent Hospital in Green Bay.

Eau Claire Physicians Present Program

Five members of the Midelfart Clinic in Eau Claire presented a scientific program at a gathering of about 40 physicians in Marshfield in December. Participating were *Dr. Donald Griffith*, Dr. James Merritt, *Dr. J. H. Wishart*, *Dr. Richard Brown* and *Dr. Peter Midelfart*.

Doctor Freeman Talks

Dr. D. J. Freeman, Wausau physician, discussed the care of cardiac and stroke patients at a meeting of the Wausau physical therapists in December. He emphasized the care of the shoulder-hand syndrome in the cardiac patient and the earliest possible activity for the stroke patient. A question and answer period followed the talk.

Kenosha Pediatrician Named Fellow

Dr. David W. Davis, Kenosha, has been elected a fellow of the American Academy of Pediatrics. Doctor Davis is one of 275 new members voted into the specialty organization.

Washington Island Welcomes New Physician

Washington Island announced in December that Dr. Paul E. Rutledge, St. Louis, Missouri, has announced his intention of opening a practice in that community. A summer resident for many years, the doctor responded to a community call for a physician.

WISCONSIN PHYSICIANS *continued*

Dr. Austin President Of Green Bay Group

Dr. S. Drake Austin, Green Bay, has been elected president of the United Community Council in that community for 1961. *Dr. Clarence Rothe* is serving as public relations chairman for the council.

Dr. Mulvaney Closes Clintonville Office

Dr. John Mulvaney closed his office in Clintonville in December to begin postgraduate work in psychiatry at Traverse City State Hospital in Michigan. Doctor Mulvaney practiced in Clintonville and Wausau for the past eight years. Prior to that he was on the staff at Winnebago State Hospital.

Doctor Pinney Opens Hilbert Practice

Dr. James C. Pinney opened a medical practice at Hilbert in January. He was formerly at Washington Island.

Cudahy Honors Doctor Kash

Cudahy's health commissioner and school physician for the past 27 years, *Dr. Sarkis H. Kash*, was honored at a testimonial dinner in that community December 7. City officials and professional men were present to honor the physician for his devoted service to the community. The doctor did not seek reappointment to the health position this year, and was succeeded by *Dr. Carl J. Chelius*.

Doctor Grigsby Announces Retirement

Dr. Roll O. Grigsby, Ashland, has retired from active practice after nearly 36 years as an eye, ear, nose and throat specialist in Ashland. Doctor Grigsby is a former president and secretary of the Ashland-Bayfield-Iron County Medical Society and served several times as president of the staff of St. Joseph's Hospital. A graduate of the University of Chicago Medical School in 1916, Doctor Grigsby was in general practice in Montana for four years before taking his specialty training at the Mayo Clinic in Rochester, Minnesota. He then established his specialty practice in Ashland. Doctor and Mrs. Grigsby will continue to reside in Ashland.

Doctor Peitersen Heads Medford Group

Dr. P. S. Peitersen, Medford, has been named chairman of the Taylor County chapter of the National Conference of Christians and Jews. This is the organization which sponsors Brotherhood Week each year.

An Associate Of Doctor Wainscott

Dr. William H. Nicolaus of Milwaukee became an associate of *Dr. Paul E. Wainscott* of Menasha on January 1, 1961, in the general practice of medicine and surgery. A 1957 graduate of the University of

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Riboflavin	1 mg.
Pyridoxine Hydrochloride	0.25 mg.
Calcium Pantothenate	0.25 mg.
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WISCONSIN PHYSICIANS *continued*

Wisconsin Medical School, Doctor Nicolaus interned in Milwaukee and was associated with the City of Milwaukee Health Department in 1958 prior to military service. He has been assigned as Director of Base Medical Services the past two years with the Air Force in Nevada.

Physicians On Dental Society Program

Six Wisconsin physicians will be appearing in various phases of the annual meeting program of the Wisconsin State Dental Society to be held at the Milwaukee Auditorium, April 24–26. Essays are to be presented by *Drs. Robert J. Samp*, Madison; *Adolph M. Hutter*, Fond du Lac; and A. L. Kappus, Milwaukee. *Drs. H. J. Lee, A. J. Quick* and *Jay J. Jacoby* all of Milwaukee, will present table clinics. Wisconsin physicians are invited to attend the meeting.

Correction

In the January Blue Book issue *Dr. William D. Brand* was listed as practicing in Wauwatosa at 2576 North 91st Street. This is his home address. Doctor Brand's office is at 238 W. Wisconsin Avenue, Milwaukee.

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Surgery of Hernia, Three Days, April 20

General Pediatrics, Two Weeks, May 1

Electrocardiography & Heart Disease, One Week, April 17

Clinical Uses of Radioisotopes, Two Weeks, May 1

Gynecology, Office & Operative, Two Weeks, April 10

Vaginal Approach to Pelvic Surgery, One Week, May 15

Obstetrics, General & Surgical, Two Weeks, May 1

Fractures & Traumatic Surgery, Two Weeks, June 12

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Surgery of the Hand, One Week, April 17

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Dr. Florence A. Duckering, the first woman physician in Sheboygan, died January 21, 1961, at the age of 48. Doctor Duckering was a specialist in obstetrics and gynecology.

Born May 16, 1912, in Boston, Mass., Doctor Duckering received her medical degree from Tufts College, Boston, in 1937. After a year of internship at the New England Hospital for Women and Children in Boston, she engaged in general practice at Roslindale, Mass., from 1938 to 1942. During this period she also served as an assistant physician at Wellesley College in Wellesley, Mass., as substitute physician in the City of Boston public schools, and as substitute physician in child and maternal hygiene for the State of Massachusetts.

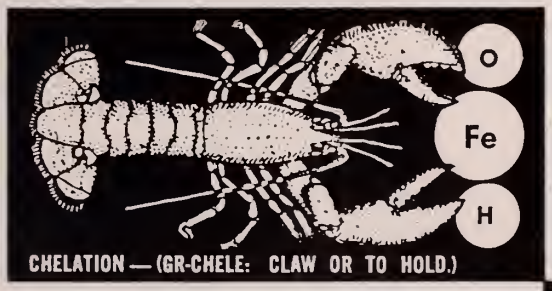
After receiving her specialty training at New York Hospital, affiliated with Cornell University, Doctor Duckering established her practice at the Sheboygan Clinic in 1945. She practiced in that community for 14 years, before retiring in 1959, due to illness.

Doctor Duckering was a member of the Sheboygan County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. She was elected to the American Board of Obstetrics and Gynecology in 1947 and became a fellow of the International College of Surgeons in 1950. Doctor Duckering also served as a diplomate on the National Board of Medical Examiners.

Doctor Duckering was noted in Sheboygan for her gentleness, kindliness, sympathetic understanding and her meticulous attention to both the physical and emotional needs of those in her care. Her deep regard for helping others was revealed in her Last Will and Testament in the numerous bequests to charitable organizations, including a $5,000 bequest to the student loan fund of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

She followed a medical heritage which included three uncles who were practicing physicians and an aunt who was the first woman gynecologist admitted to the American College of Surgeons.

Her only survivors are four cousins.



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NEWS FROM THE MEDICAL SCHOOLS

Radiology Departments Established

Departments of Diagnostic Radiology and Radiation Therapy have been established by the Marquette University School of Medicine, Dean John S. Hirschboeck has announced.

The creation of the two new departments is the latest move in an academic expansion program of the medical school and brings to six the number of departments added within the last 10 years.

John R. Amberg, M.D., Director of Radiology at Milwaukee County Hospital, has been appointed Associate Professor and Chairman of the Diagnostic Radiology Department. Doctor Amberg has been affiliated with the county hospital since 1958 and formerly was Assistant Professor of Radiology. He received his undergraduate and medical training at the University of Minnesota and prior to his Milwaukee appointments was on the teaching staff at the Minnesota Medical School.

S. A. Morton, M.D., Director of Radiology at Milwaukee Columbia Hospital and Professor of Radiology, assumes chairmanship of the Division of Radiology and will be acting departmental chairman of Radiation Therapy.

Combined Degree Program Established

A combined degree program for the degrees of doctor of medicine and doctor of philosophy in pharmacology has been established at the Marquette Medical School under a U.S. Public Health service grant of $89,775. One of the first of its kind in the country, the award was made to Harry Beckman, M.D., Ph.D., Professor and Chairman of the Department of Pharmacology.

Open to medical students who have completed the first two years of basic science work in medicine, the new program will offer support for the final two years of clinical study, plus three years of postgraduate work in pharmacology. Students qualifying for the award will receive an annual stipend of $3,600 plus tuition and fees. Initially one student will be enrolled for the 1961–62 academic year and in each succeeding year another will be brought into the program.

UW Research Project

Research at the University of Wisconsin Medical Center, Madison, on epilepsy and Parkinsonism—the two most prevalent neurological ailments—has revealed the effectiveness of a number of new drugs for alleviating the symptoms and greatly increasing the ability of patients to take part in normal daily activities.

While Wisconsin medical scientists emphasize that probably there will never be just one "miracle" drug for all victims of each disease, improved methods of treatment are now available and it is hoped that it will be possible eventually to exercise considerable control over the diseases.

Epilepsy affects 700,000 to one million people in the United States—people of any age. Parkinsonism affects 400,000 to one-half million people, and its prevalence increases with age, taking a real jump after age 50.

The search in the UW Medical Center for new and improved anticonvulsant drugs to control epileptic seizures is under direction of Dr. Francis Forster, chairman of the department of neurology. He points out that much of the current research effort is concerned with evaluation of certain chemical compounds called succinimides, of which one, called Quanavar, holds considerable promise. Patients are studied in the epilepsy clinic, established two years ago.

In charge of the search for anti-Parkinsonism drugs is Dr. Hartwell G. Thompson, Jr. Currently three new drugs are being tested in the Parkinsonism clinic which has been in existence for one year. One is called Phenoxene; it helps control rigidity, a common complaint of Parkinsonism sufferers.

One of the biggest problems in control of these two diseases of the central nervous system is that very litle is known about the actual nature of any drug's action in the nerve cell.

In laboratory experiments, intoxicating drugs are given to animals or they are subjected to operations to see if Parkinsonism can be produced. In the UW department of pharmacology, a drug called Tremorine is being used to produce Parkinsonism-like tremors in mice. Various drugs are then tested for their abilities to control these artificially produced tremors.

The surgical approach to the disease has been explored, too. Concerning epilepsy, Doctor Forster says that "certain patients whose seizures cannot be controlled with medicine and whose seizures are shown to arise from one particular part of the brain may be helped by incision of this portion."

Surgery in Parkinsonism has not proved to be a perfect type of therapy, although it has yielded some encouraging results.

The medical profession has received generous support in this new work on neurological illnesses from the National Institute of Neurological Diseases and Blindness, a division of the Pubic Health Service.

Eben J. Carey Lecturer Named

Eugene P. Pendergrass, M.D., Professor and Chairman of the Department of Radiology at the University of Pennsylvania, will deliver the annual Phi Delta Epsilon Eben J. Carey lecture in the Marquette Medical School Auditorium, March 24.

Doctor Pendergrass will speak on "Consideration of Some of the Difficulties Encountered in the Roentgen Diagnosis of Small Carcinomas of the Lung."

University of Wisconsin Long Range Medical Center Development Planned

A major administrative development reached fruition on January 6, 1961, when the University of Wisconsin Board of Regents approved a Long Range Development plan for the Medical Center. Climaxing several months of study by a Medical Center Committee and the Institutional Planning Staff, the plan provides a logical, flexible pattern of development designed to meet the need for all new facilities envisioned for the next 20 years.

The salient feature of the plan is a high rise (10–to–12 story) building, extending from the current D wing of the Hospital, through the site of the present North wing of the infirmary, to a westerly point near the Interns and Residents Dormitory.

This unit would tie together several of the dispersed areas of the Medical Center complex and provide a back drop for the Medical Library and the main Hospital building mass. With the principle of vertical expansion to this height approved, many space problems can be solved. Elements of the high rise building may be constructed individually as program developments and availability of funds permit. The first unit might be the new Cancer Research Building. Clinical facilities or other research institutes might also be included.

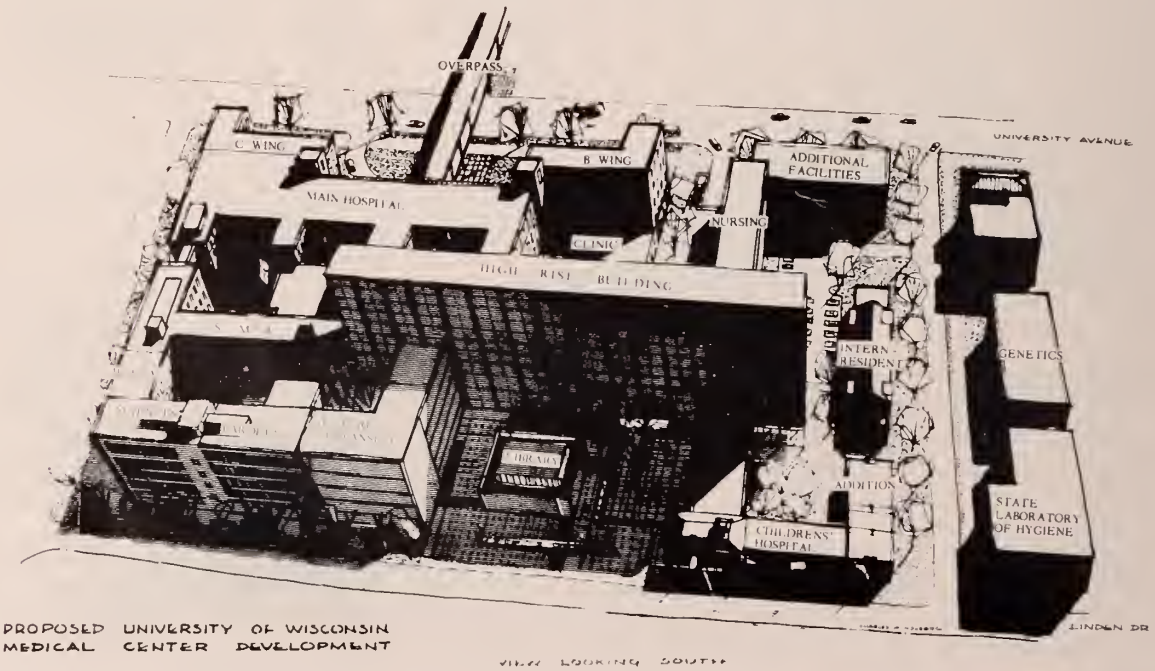
A new and more desirable site for the Medical Library is established on Linden Drive, immediately north of the eventual high rise building. Surrounded by greensward and with no encroaching buildings, the Library will be the focal point for the Medical Center campus on the north.

A campaign to raise funds for the William S. Middleton Medical Library was undertaken by the Wisconsin Medical Alumni Association two years ago. Gifts and pledges now total $510,000 and construction of the building should be begun in 1961.

The ubiquitous parking problem may be solved by the development of a parking ramp south of University Avenue on the site of a current parking lot. Space is now available for a ramp providing 350 parking stalls. Eventual expansion to approximately 1,000 available parking stalls is planned. The parking ramp would be reached by an elevated walkway over University Avenue entering the main hospital.

A proposed educational building for the Nursing, Occupational Therapy and Physical Therapy programs is located in the plan on North Randall Avenue abutting into the high rise building.

Future expansion of basic science facilities is envisioned on Linden Drive—an L shaped structure adjoining the Bardeen Building and extending west across the current ambulance entrance and south at the present site of Bradley.



PROPOSED UNIVERSITY OF WISCONSIN MEDICAL CENTER DEVELOPMENT

VIEW LOOKING SOUTH

Significant to the hospital programs is a proposed clinic building to the west of the Hospital on the current site of the Infirmary and the addition of two stories to the B and C wings of the Hospital. These additions are urgently needed to replace the beds which will be lost in the Hospital remodeling program converting large wards to single and double rooms.

The plan also provides for an eventual addition to the Children's Hospital, a new institute building (possibly Rehabilitation or Geriatrics) on the site of the Nurses Dormitory and another institute south of University Avenue (possibly a Psychiatric Institute, on the site of the current old University Heating Station and Service Building).

The aesthetic values of the Medical Campus would be greatly enhanced by a planned elevated Mall extending from University Avenue to Linden Drive on Randall Avenue. Vehicular traffic to the clinic Building and Hospital Service entrance would be directly from University Avenue beneath the Mall.

Particularly attractive features of the plan are its flexibility and its ease of implementation as funds become available, without razing major buildings and disrupting programs. The Medical Library, the Cancer Research Building, the School of Nursing Building, and the first unit of the parking ramp can all be constructed with only the razing of several houses required.

Elected to Royal Society

Donald Greiff, Sc.D., Professor in the Department of Pathology at Marquette, has been elected an affiliate member of the Royal Society of Medicine, London. Doctor Greiff was nominated for the honor in October and his election was announced in January.

Founded in 1805, the Royal Society of Medicine is one of England's foremost bodies of physicians and scientists engaged in both basic science and clinical research.

Dr. Greiff has been doing research on the effects of low temperatures on viruses with particular emphasis on preservation of live vaccines in a dried state and of cells and tissues in both frozen and dried states.

A graduate of Marquette University, Doctor Greiff earned his Sc.D., at Johns Hopkins and was affiliated with the department of biology at St. Louis University for 15 years before coming to Marquette in 1957.

Adolf Gundersen Visiting Professor

Dr. Maxwell Finland, Associate Professor of Medicine, Harvard Medical School, will visit the University of Wisconsin Medical Center the week of March 26 as an Adolf Gundersen Visiting Professor. This program, financed by an annual gift from the Adolf Gundersen Medical Foundation of La Crosse, enables the medical school to bring distinguished medical scientists to its campus every year.

Doctor Finland, who is Associate Director of the Thorndike Memorial Laboratories and Physician-in-Chief, Fourth Medical Service, Boston City Hospital, is a noted authority on antibiotics and infectious diseases. He will lecture at Convocation Wednesday, March 29, at 4:00 P.M., in Service Memorial Institutes Auditorium and will discuss a C.P.C. on Tuesday, March 28, at 4:00 P.M., in the S.M.I. Auditorium.

Gifts And Grants Received

Gifts and grants received by the University of Wisconsin Medical Center total $2,290,809.50 for the first six months of 1960–61. The figures released by Dr. John Z. Bowers, Dean, show an increase of $350,218.73 over the same six-month period last year.

The primary source of research funds continues to be United States governmental agencies, $1,921,278; with the remaining sum being contributed by Voluntary Health Agencies, individuals, industries and foundations.

The grants cover research and training programs in all of the twenty-three departments of the Medical Center.

Research Grants Awarded

Five research grants totalling $66,411 have been awarded the Marquette University Medical School by the Atomic Energy Commission and the U.S. Public Health Service.

Donald Greiff, Sc.D., Professor in the Department of Pathology, has been awarded an Atomic Energy grant of $25,000 for the study of "Relations of Rickettsial and Viral Infections to Radiation Injury."

Doctor Greiff and C. P. Erwin, M.D., Assistant Professor of Pathology, were awarded a grant of $1,946 from the U.S. Public Health Service for a study of the "Oncolytic Activities of the Rickettsia."

Other Public Health awards were made to Warren H. Kempinsky, M.D., Associate Professor of Neurology, $15,000 for a neurology training program; Harold F. Hardman, M.D., Ph.D., Associate Professor of Pharmacology, $4,194 for "Analysis of Sympathomimetic Receptors;" Willard A. Krehl, M.D., Ph.D., Associate Professor of Medicine, $20,211 for "Experimental and Clinical Studies of Pyelonephritis."

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C. W. Schmidt, Marshall, to 5308 Brody Drive, Madison.

D. E. Chisholm, Buena Park, Calif., to 2407 North Logan, Colorado Springs, Colo.

P. E. Podruch, Milwaukee, to Dept. of Pediatrics, 1300 University Avenue, Madison.

D. J. Cohen, Pensacola, Fla., to Navy Administration Com. N. D. C., Great Lakes, Ill.

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MEDICAL MEETINGS—POSTGRADUATE COURSES

Wisconsin Urological Society

The Wisconsin Urological Society will hold its annual meeting on Saturday, April 15. The one-day session will take place at the Milwaukee Inn, East State at the Lake, Milwaukee. The principal speaker will be Wyland Leadbetter, M.D., F.A.C.S., Chief of Urology, Massachusetts General Hospital, Boston, Mass.

Metta Bean Lectures Announced

Dr. Otto Pollak, professor of sociology, Wharton School, University of Pennsylvania, will be the fifth annual Metta Bean lecturer, speaking on "Family Dynamics in Various Cultures."

The lectures will be given at 8 p.m., Tuesday, March 28, in the Student Union Lounge, 2200 E. Kenwood Blvd., University of Wisconsin–Milwaukee; and on Wednesday, March 29, at the Wisconsin Center, University of Wisconsin, Madison. Students, faculty and practicing social workers, as well as the public, are invited to attend.

The Metta Bean Lecture is co-sponsored each year by the University of Wisconsin School of Social Work and the Wisconsin Anti-Tuberculosis Association in honor of the founder and long-time head of the WATA's Social Service Department, who retired in 1956.

Doctor Pollak is a member of the New York Academy of Science and the American Orthopsychiatric Association, and has published several texts in his field. He is a graduate of the University of Vienna, Bryn Mawr College and the University of Pennsylvania.

WATA Annual Meeting

An advertising firm's projection of the changing face of America will be applied to Wisconsin's needs in TB control and public health at the 1961 annual meeting of the Wisconsin Anti-Tuberculosis Association.

The meeting will be held April 13 and 14 at the Schroeder Hotel, Milwaukee.

"Interurbia," a presentation outlining the most significant changes in American life as they will occur in the next decade, will keynote a symposium relating to the organization of health and welfare programs with emphasis on improvement of local health services. The forecast was developed by J. Walter Thompson Company, Chicago and will be presented by K. H. Halverson, account executive.

Further information on program and reservations may be obtained from the WATA, P.O. Box #424, Milwaukee 1, Wisconsin.

American College of Gastroenterology

The Central Regional Meeting of the American College of Gastroenterology will be held in Milwaukee, Sunday afternoon, April 16. The scientific ses-

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sions will be held at the Schroeder Hotel at 2:00 P.M., following the semi-annual meeting of the College's Board of Trustees.

Participating in the meeting will be Dr. Andrew E. Cyrus, Jr., Milwaukee; Dr. D. O. Ferris, Rochester, Minn.; Dr. John Hurley, Milwaukee; Dr. Raymond J. Jackman, Rochester, Minn.; Dr. LeRoy Sims, Madison, and Dr. Jean Spencer, Chicago, Ill.

Dr. Edwin H. Ellison and Dr. Robert T. McCarty, both of Milwaukee, are the Chairmen of the Program and General Arrangements Committees, respectively.

The Central Region consists of the states of Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota and Wisconsin.

Members of the medical profession are cordially invited to attend. A copy of the program may be obtained by writing to the Secretary, American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

American College of Physicians

The 42nd annual session of the American College of Physicians will be held at the Americana Hotel, Miami Beach, Florida, May 8–12.

In addition to the scientific session which includes Basic Science, Clinical Investigation Sessions and T.V. Sessions there will be entertainment including a "Pops" concert by the Miami University Symphony Orchestra. The president of the Rockefeller Foundation will be the speaker at the Convocation.

For further particulars write to: ACP, 4200 Pine Street, Philadelphia 4, Pa.

World Congress in GYN & OB

The 3rd World Congress of the International Federation of Gynaecology and Obstetrics will be held in Vienna from September 3 to 9.

The scientific program will include main lectures, colloquia, fireside conferences and so on.

Chiefly the following subjects will be the topic of discussions:

I. Surgical treatment in gynecology and obstetrics: conservative operations of fibroids, operations of stress incontinence, operations of aplasia vaginae, surgical treatment of Carcinoma of the Collum, treatment of incompetent cervical os, forceps, vacuum extractor, treatment of breech presentation, and anesthetics in cesarean section.

II. The role of the pituitary gland in the physiology and pathology of genital organs: diagnosis and treatment in Sheehan's disease, treatment with Gonadotropin in anovulatory cycles, and induction of labour with Pituitrin.

Some 3,000 participants are expected to attend.

SPRING POSTGRADUATE MEETING
OF THE
JACKSON CLINIC AND FOUNDATION

Loraine Hotel, Madison — **Wednesday, April 19, 1961**

1:30 Registration

PART ONE: Chairman—W. B. Parsons, Jr., M.D.

2:00 Welcome
ARNOLD S. JACKSON, M.D.

2:05 Ectopic Pregnancy
BARBARA A. BREW, M.D. (Obstetrics & Gynecology)

2:25 "Doc—I Got Sinus"
THEODORE L. HARTRIDGE, M.D. (Otolaryngology)

2:45 Chest Diseases Diagnosed by Thoracotomy
OSCAR F. FOSEID, M.D. (Thoracic Surgery)

3:05 Skin Lesions—Dangerous or Not?
VAUGHN E. DEMERGIAN, M.D. (Plastic Surgery)

INTERMISSION

PART TWO: Chairman—Arnold S. Jackson, M.D.

3:40 Depression—Presenting as Somatic Symptoms
FRANK WINSTON, M.D. (Guest Speaker) (Psychiatrist—2700 Marshall Court, Madison)

4:00 Cirrhosis of the Liver
ROBERT A. STRAUGHN, M.D. (Internal Medicine)

4:20 Insufficiency of the Cerebral Circulation
JOHN H. MORLEDGE, M.D. (Internal Medicine)

5:10 **QUESTION AND ANSWER PERIOD:**
Moderator—W. B. Parsons, Jr., M.D.
Questions may be directed to the speakers or the following panelists:
HUBERT C. ASHMAN, M.D. (Medicine)
LUTHER E. HOLMGREN, M.D. (Surgery)
HOWARD W. MAHAFFEY, M.D. (Orthopedic Surgery)
DAVID L. WILLIAMS, M.D. (Obstetrics & Gynecology)

5:30 **SOCIAL HOUR AND SUPPER**
(Wives of visiting doctors included)

WISCONSIN CALENDAR COMING EVENTS

1961

Apr. 5: Cancer-Heart Institute, Luther Hospital, Eau Claire.

Apr. 5, 12, 19, 26: Postgraduate course, Gastroenterology, Marquette U. Sch. of Med., Milwaukee.

Apr. 13–14: Annual meeting, Wisconsin Anti-Tuberculosis Association, Hotel Schroeder, Milwaukee.

Apr. 13–15: Hematologic Disorders in Pediatrics, UW postgraduate course, Wisconsin Center Building, Madison.

Apr. 15: Annual meeting, Wisconsin Urological Society, Milwaukee Inn, Milwaukee.

Apr. 16 Central regional meeting, American College of Gastroenterology, Milwaukee.

Apr. 19: Spring postgraduate meeting, Jackson Clinic and Foundation, Loraine Hotel, Madison.

Apr. 24–26: Wisconsin State Dental Society annual meeting, Milwaukee.

Apr. 25: Meeting, Milwaukee Oto-Ophthalmic Society, Univ. Club, Milwaukee.

Apr. 30: Opening of Museum of Medical Progress, Prairie du Chien.

May 2–3–4: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 11–13: Pathology and Radiology of Chest Diseases, UW postgraduate course, Wisconsin Center Building, Madison.

May 20–21: Wisconsin Association of Blood Banks, meeting, Conway Hotel, Appleton.

May 23: Annual social meeting, Milwaukee Oto-Ophthalmic Society, Univ. Club, Milwaukee.

May 24: Maternal Mortality Institute, St. Mary's Hospital, Wausau.

June 21: Conference on Medical Aspects of Mental Retardation, Brooks Auditorium, Milwaukee.

June 26–30: AMA Annual Meeting, New York, New York.

Aug. 29–31: UW Postgraduate course, Psychiatric symposium, Dr. R. Roessler, chrm., Wisconsin Center Building, Madison.

Sept. 28–30: UW postgraduate course, Anesthesiology, Dr. O. S. Orth, chrm., University Hospitals, Madison.

Oct. 13–14: UW postgraduate course, Psychiatry, Dr. R. Roessler, chrm., Wisconsin Center Building, Madison.

Nov. 16–18: UW postgraduate course, Rehabilitation of Patients with Injuries of the Spinal Cord, Dr. A. Siebens, chrm., Wisconsin Center Building, Madison.

Nov. 28–Dec. 1: AMA Clinical Meeting, Denver, Colorado.

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PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 15th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where department numbers follow advertisements, replies should be addressed in care of The Wisconsin Medical Journal.

WANTED: BOARD INTERNIST and Board Pediatrician for stable college town of 35,000 in growing Southwest, excellent climate. Write to: Andrew M. Babey, M.D., 250 West Court Avenue, Las Cruces, New Mexico. 2

DOCTOR'S OFFICE SPACE AVAILABLE in beautiful new Brentwood Medical Arts Building, 2018 North Sherman Avenue, Madison. Private doctors' parking, public parking, (40 cars), acoustical ceiling, mahogany paneling, heat and air conditioning, large reception room, black top parking area, pharmacy in building. On bus line, convenient to schools and churches. Address replies to Dept. 715 in care of the Journal. tfn

MODERN MEDICAL OFFICE SPACE available in large, growing residential area. New air-conditioned building. Off-street parking. Excellent opportunity for large practice. Hospital facilities readily available. Write: D. A. Boville, D.D.S., 984 Ninth Street, Green Bay, Wisconsin. 12tf.

WANTED: PHYSICIAN for general practice. Three-man group. Excellent opportunity. Permanent. Contact Dept. 903 in care of the Journal. m3–5

FOR SALE: Portable office G. E. x-ray unit, with tanks and 14 x 17 cassettes, first class condition. Write or call E. G. Welke, M.D., 1310 Morrison, Madison, Wisconsin, ALpine 6–7626. M10tfn

WANTED: Otolaryngologist and an ophthalmologist needed for EENT group in Milwaukee. Splendid opportunity for right men. Men are to be certified or Board eligible. Personal interview to discuss details of association. Contact Dept. 904 in care of the Journal. m3tfn

FOR RENT: Thiensville medical offices in new ranch professional building. Ample parking. Prosperous, fast-growing Milwaukee suburb. Contact K. W. Clemence, D.D.S., Chestnut 2–3460, Thiensville, Wisconsin. 3–5

FOR SALE: Active EENT practice established 35 years ago. Located in Milwaukee. Contact Dept. 901 in care of the Journal. m3–4

WANTED: Young general practitioner or internist to join general practitioner in well established practice in northern Wisconsin. Initial salary with early partnership privileges. Newly remodeled, well equipped clinic. Excellent year-around recreational facilities, schools, and living conditions. Contact Dept. 902 in care of the Journal. m3–4

WANTED: PEDIATRICIAN, Board eligible, to join department of two Board certified men in 13-man group located in southern Wisconsin city of 35,000. Partnership opportunity available. Contact Dept. 883 in care of the Journal. 12–3

WANTED: MEDICAL DIRECTOR for institution for the retarded. General practice and administrative experience required. Salary $14,160 to $21,060 depending on qualifications. Write: Mr. A. C. Nelson, Superintendent, Northern Colony and Training School, Chippewa Falls, Wisconsin. g11tf

WANTED: MEDICAL DIRECTOR for institution for the retarded. Specialty in pediatrics or internal medicine required. Staff of five physicians plus consultants in all specialties. Salary $18,660 to $21,060 depending on qualifications. Write: Mr. John M. Garstecki, Superintendent, Southern Colony and Training School, Union Grove, Wisconsin. g11tf

FOR SALE: Microtherm machine, less than one year old. R. M. Rogers, M.D., 7259 West Lakefield Avenue, Milwaukee 19, Wisconsin. m2–3

WANTED: PHYSICIAN to share a clinic which is now occupied by an M.D. and a D.D.S., located in a prosperous Southeastern Wisconsin industrial and farming community where the need for another physician is very great. Contact Dept. 827 in care of the Journal. 3tf

WANTED: GENERAL PRACTITIONER. Mideastern Wisconsin general practitioner desires associate, preferably a man with an interest in surgery. One year salary, then profit percentage leading to an equal partnership.

ALSO

SPACE AVAILABLE in recently remodeled Doctor's Building for a man who desires solo practice. Contact Dept. 887 in care of the Journal. m1–6

POSITION WANTED: General practitioner, age 31, desires salaried position in or near Madison. Regular hours preferred. Experience includes one year of surgical training. Contact Dept. 895 in care of the Journal. p2

WANTED: GENERAL SURGEON for three G.P. partnership in well established practice in northwestern Wisconsin. New clinic building. Full laboratory, x-ray, examining rooms, minor surgery. Near metropolitan area of 150,000. Liberal salary first year. Partnership second year. Contact Dept. 896 in care of the Journal. p3–4

WANTED: GENERAL PRACTITIONER to join two G.P.s in well established practice in northwestern Wisconsin. New physician will replace physician who is leaving for residency training. Modern, well equipped clinic building. City of 35,000. Near metropolitan area of 125,000. Salary first year. Partnership second year. Contact Dept. 897 in care of the Journal. p3–4

POSITION WANTED: General practitioner, FAAGP, age 36, diplomate of National Board, graduated 1953, married with two children, presently in group practice, would like to move to Wisconsin; special interest OB and Pediatrics; general anesthesia experience; interested in purchasing practice or association. Contact Dept. 898 in care of the Journal. 3

POSITION WANTED: Internist-Gastroenterologist, Board eligible, first class training, desires partnership or association with group, clinic or hospital. Contact Dept. 899 in care of the Journal. p3

WANTED: LOCUM TENENS POSITION. Ophthalmology resident, in final year of training, available for one month or less in July, August or September. Contact Dept. 900 in care of the Journal. p3–4

WANTED: GENERAL PRACTITIONER interested in associating with two other general practitioners in southern Wisconsin. Partnership if interested. Contact Dept. 856 in care of the Journal. m2–3

SPACE AVAILABLE: Modern medical office space available on ground floor. Off-street parking. Modern hospital 5 miles distant. Equipment of deceased physician, if desired. Write or call Jerry M. Slechta, Jefferson, Wisconsin. m2–3

OPENINGS AVAILABLE: 25-men group practice desires 2 ophthalmologists, 1 psychiatrist, 1 orthopedist, 1 allergist, 1 proctologist, and 3 general practitioners. Inquire of R. G. Zach, M.D., The Monroe Clinic, Monroe, Wisconsin. 2tf

the Wisconsin Medical Journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

VOL. 60, NO. 4—APRIL 1961

STATE MEDICAL SOCIETY OF WISCONSIN
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LETTERS OF INTEREST

CALIFORNIAN VIEWS CHIROPRACTIC

To Doctor Goldstein:

Enjoy your literate editorials in the *Wisconsin Medical Journal* very much. In reference to your latest on chiropractic, I'm sure you would enjoy a short piece by H. L. Mencken which can be found in any collection of his newspaper articles, for it is a classic. His approach is less paternalistic than your own but probably more effective.

Has anyone ever thought to run a column answering the claims of the chiropractic ads in the daily newspaper, or does the AMA find this too expensive? Do not we countenance their claims by failing to rebut them? Keep up the good work.

M. J. Valaske, M.D.
LCDR (MC) USN
San Diego Naval Hospital

MENTAL HEALTH PROGRAMS

To SMS:

The copy of the address by Dr. Maurice E. Linden was much enjoyed. Thank you and Doctor Tenney for your thoughtfulness.

Henry Veit, M.D.
5836 W. Lisbon Avenue
Milwaukee 10, Wisconsin

To SMS:

I want to thank you and commend Dr. H. Kent Tenney for sending out the article by Dr. Maurice E. Linden, entitled "The Older Person, Family Life and Community Mental Health Programs." This article is one of the outstanding expressions of thought upon the chaotic situation that exists in America today that I have seen. He expresses ideas here which apply not just to the older person and his problems but to problems at all age levels in the whole area of social problems. This paper cannot be too widely disseminated and too widely read. I wish it could be shouted from every roof top each morning, instead of having the seven o'clock whistle blow. Sending out this article is a very real service.

Carl L. Kline, M.D.
Medical Director
Child Guidance Center of
Marathon County, Inc.
St. Mary's Hospital
Wausau, Wisconsin

Physicians who might have received letters which would be appropriate for this section are invited to submit them to the Journal editorial office for consideration. The Journal also welcomes letters from physicians who might have something of interest to relate to the membership. Address letters to: Wisconsin Medical Journal, Box 1109, Madison 1, Wisconsin.

ATTENTION: REGISTERED PROFESSIONAL NURSES

The Office Nurses Section of the Wisconsin Nurses Association invites all registered professional nurses, and particularly office nurses, to attend a one day educational institute to be held Saturday, May 6, 9:00 a.m. to 4:00 p.m. in the Sky Room, St. Mary's Hospital, 2320 North Lake Drive, Milwaukee.

The program "Taking a Look at Office Nursing" will include a panel discussion on patient-nurse relationships, physician-nurse relationships, and the legal aspects of office nursing. Participants will be an office nurse, a physician, an attorney, and representatives of the State Department of Nurses and the State Department of Pharmacy. There will be an opportunity for the audience to have questions answered.

The afternoon session will include a visit to the Burn Center of St. Mary's Hospital, to be followed by a lecture and demonstrations by a physician and nurse from the Burn Center team.

A nominal fee will be charged for the institute. For further information and/or advanced reservations write to Mrs. Florence Kobus, R.N., Chairman, Committee on Program, WNA Office Nurses Institute, Wisconsin Nurses Association, Room 6012, 161 West Wisconsin Avenue, Milwaukee.

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FOUNDATION PROGRESS

A SERVICE MADE POSSIBLE

Through a grant from the Wisconsin Council for Mentally Retarded Children, the CES Foundation is able to present a statewide conference on "Medical Aspects of Mental Retardation," to be held in Brooks Memorial Union Building of Marquette University, Milwaukee, on June 21.

This important conference is designed to assist all physicians confronted with problems of mental retardation in their practice. Emphasis will be placed on parent counseling, evaluation of mental retardation, educational opportunities for children with mental deficiencies, and current research of special interest to physicians.

A program on this conference appears in this issue of the Journal on page 62.

This is another example of how agencies concerned with health problems can utilize the experience and "know how" of the CES Foundation to provide teaching programs directed to physicians in areas of special interest.

It is anticipated that in the years ahead conferences of a similar nature, on different topics of interest to Wisconsin physicians, will be made available through cooperative efforts of the Foundation and "outside" organizations.

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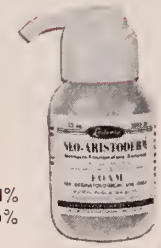

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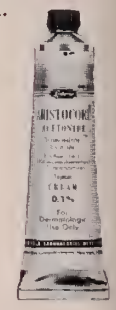

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The anti-inflammatory and antipruritic efficacy of triamcinolone acetonide was shown by the prompt control of itching and resolution of affected areas. Cahn, M. M., and Levy, E. J.: A Comparison of Topical Corticosteroids: Triamcinolone Acetonide, Prednisolone, Fluorometholone, and Hydrocortisone.

Antibiotic Med. & Clin. Ther. 6:734 [Dec.] 1959.

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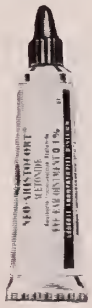

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Wisconsin Medicine Progressing in a Free Society

STATE MEDICAL SOCIETY OF WISCONSIN

ANNUAL MEETING

MAY 2, 3 and 4, 1961

MILWAUKEE AUDITORIUM

HOTEL SCHROEDER—MILWAUKEE

R. B. LARSEN, M.D.
General Program Chairman

M. C. F. LINDERT, M.D.
Chairman, Commission on Scientific Medicine

R. W. FARNSWORTH, M.D.
Chairman, Roundtable Luncheons

Each year brings new discoveries and varying modes of therapy of concern to every alert physician. With this in mind the Commission on Scientific Medicine has arranged a varied and interesting program for the 1961 Annual Meeting. *Wisconsin Medicine Progressing in a Free Society* is an apt theme, and we hope that you and your associates will participate in the meeting by way of your attendance. You will note that the major specialty groups, as well as the area of general practice, are represented in the program. Thinking of our responsibilities to all segments of the profession, we have attempted to provide a variety of programs for your benefit. We urge you to progress with Wisconsin Medicine by attending the Annual Meeting and attending programs of special interest to you.

Sincerely,

M. C. F. Lindert, M.D.

Chairman, Commission on Scientific Medicine

1961 ANNUAL MEETING

TIMETABLE

MONDAY, MAY 1

All Day—Golf Tournament: Ozaukee Country Club
7:00 p.m.—House of Delegates at Hotel Schroeder

TUESDAY, MAY 2

8:00 a.m.—Registration at Auditorium
Exhibits open at Auditorium
9:00 a.m.—Reference Committees, House of Delegates, at Hotel Schroeder
10:00 a.m.—Clinical Conferences: Marq. U. and U. of W. medical schools, Milwaukee Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Marq. U. and U. of W. medical schools' alumni luncheons at Auditorium
2:00 p.m.—Section Meetings on Internal Medicine, Obstetrics and Gynecology, Pathology and Psychiatry at Auditorium
6:00 p.m.—Buffet for Delegates and Officers at Hotel Schroeder
7:00 p.m.—House of Delegates at Hotel Schroeder
8:00 p.m.—Fireside conferences at Hotel Schroeder

WEDNESDAY, MAY 3

8:00 a.m.—Registration at Auditorium
9:00 a.m.—Exhibits open at Auditorium
9:00 a.m.—House of Delegates at Hotel Schroeder
9:00 a.m.—Internal Medicine Program at Auditorium
10:00 a.m.—General Practice Program at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Luncheon for officers and members of SMS Charitable, Educational and Scientific Foundation at Hotel Schroeder
12:15 p.m.—Luncheon for Wisconsin Clinic Managers Association at Milwaukee Athletic Club
2:00 p.m.—Section Meetings on General Practice, Gastroenterology, Orthopedic Surgery and Pediatrics at Auditorium
6:15 p.m.—President's reception
7:15 p.m.—Annual dinner

THURSDAY, MAY 4

8:00 a.m.—Registration at Auditorium
9:00 a.m.—Exhibits open at Auditorium
10:00 a.m.—General Scientific Program at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Past president's luncheon
1:00 p.m.—Program on Ophthalmology and Otolaryngology at Hotel Schroeder
2:00 p.m.—Section Meetings on Anesthesia, Radiology, and Surgery at Auditorium

ANNUAL MEETING PROGRAM
ARRANGEMENTS UNDER DIRECTION OF

Commission on Scientific Medicine

M. C. F. Lindert, M.D., Chairman—Milwaukee
Roy B. Larsen, M.D.—Wausau
General Program Chairman
Richard Farnsworth, M.D.—Janesville
Roundtable Luncheons
Anthony R. Curreri, M.D.—Madison
Scientific Exhibits
P. T. Bland, M.D.—Westby
Special Assignments
John Z. Bowers, M.D.—Madison
Dean, University of Wisconsin Medical School
J. S. Hirschboeck, M.D.—Milwaukee
Dean, Marquette Universty School of Medicine
R. S. Baldwin, M.D.—Marshfield
Medical Editor, *The Wisconsin Medical Journal*

★ ★ ★

★ REGISTRATION: Pick up your badge at the registration desk, inside of main entrance of Milwaukee Auditorium, Fifth and Kilbourn Streets. The time: Tuesday, 8:00 a.m.–4:30 p.m.; Wednesday and Thursday, 8:00 a.m.–4:00 p.m. Admittance by badge only.

★ CERTIFIED GUESTS: Medical students, medical assistants and hospital personnel will be admitted on Wednesday, May 3, after 12:00 noon, or Thursday, May 4, between 9:00 a.m. and 3:00 p.m. Interns and residents admitted without registration fee, if certified by hospital. Members of the Wisconsin State Dental Society and out-of-state physicians who are members of their county and state medical societies admitted by membership cards.

★ VA AND M.D.'s IN MILITARY SERVICE: *Members of the Veterans Administration must be members of the State Medical Society to be admitted.* Physicians in the armed services admitted by presenting certification of current military status.

BEFORE LEAVING FOR MEETING

GIVE YOUR SECRETARY THIS INFORMATION

TELEPHONE SERVICE: Registration Desk, Milwaukee Auditorium—BR 1–9609. *For Milwaukee MDs, Direct call through BR 1–4131 and it will be relayed to a special phone near the main meeting hall at the Auditorium.* For those at Luncheons: 5th Floor Foyer phone at Hotel Schroeder—BR 1–7250. Tell your secretary the room number of the luncheon, so we can locate you!

Out-of-State Guest Lecturers...

HOLLIS G. BOREN, M.D.
Director of Research Laboratories, Veterans Administration Hospital, Houston, Tex.

DAVID T. CARR, M.D.
Assistant Professor of Medicine, Mayo Foundation Graduate School, University of Minnesota, Rochester, Minn.

TAGUE CHISHOLM, M.D.
Clinical Associate Professor of Surgery, University of Minnesota Medical School, Minneapolis, Minn.

GEORGE D. DAVIS, M.D.
Section of Diagnostic Roentgenology, Mayo Clinic, Rochester, Minn.

M. EDWARD DAVIS, M.D.
Joseph Boliver De Lee Professor of Obstetrics and Gynecology and Chairman, Department of Obstetrics and Gynecology, University of Chicago Medical School, Chicago, Ill.

EDWIN J. DE COSTA, M.D.
Associate Professor of Obstetrics and Gynecology, Northwestern University School of Medicine, Chicago, Ill.

BENJAMIN FELSON, M.D.
Professor and Director, Department of Radiology, University of Cincinnati, Cincinnati, Ohio.

MR. HARRY W. GINTY
Vice-president, The Medical Protective Co., Fort Wayne, Ind.

J. R. HELLER, M.D.
President, Memorial Sloan-Kettering Cancer Center, New York City.

JEROME A. HILGER, M.D.
Clinical Professor of Otolaryngology, University of Minnesota Medical School, Minneapolis, Minn.

ROBERT C. HORN, M.D.
Department of Pathology, Henry Ford Hospital, Detroit, Mich.

HAROLD ISRAEL, M.D.
Associate Professor of Internal Medicine, Graduate School, University of Pennsylvania, Philadelphia, Pa

ALAN J. KANTER, M.D.
Chief of Hypertensive Clinic, Michael Reese Hospital, Chicago, Ill.

KENNETH K. KEOWN, M.D.
Professor of Anesthesiology, University of Missouri Medical Center, Columbia, Mo.

GEORGE B. LOGAN, M.D.
Section of Pediatrics, Mayo Clinic, Rochester, Minn.

D. B. RADNER, M.D.
Director, Chest Department, Michael Reese Hospital, Chicago, Ill.

KENNETH L. ROPER, M.D.
Professor of Ophthalmology, Northwestern University School of Medicine, Chicago, Ill.

J. L. A. ROTH, M.D.
Associate Professor of Gastroenterology, University of Pennsylvania Graduate Medical School, Philadelphia, Pa.

RICHARD C. SCHNEIDER, M.D.
Associate Professor of Neurosurgery, University of Michigan Medical School, Ann Arbor, Mich.

SOMERS H. STURGIS, M.D.
Clinical Professor of Obstetrics and Gynecology, Harvard Medical School, Boston, Mass.

FREDERICK VAN BERGEN, M.D.
Associate Professor of Anesthesiology, University of Minnesota, Minneapolis, Minn.

OWEN H. WANGENSTEEN, M.D.
Professor of Surgery, University of Minnesota Medical School, Minneapolis, Minn.

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8:00 p.m.

TICKETS: $3.75, $2.85, $1.50—SEND CHECK AND SELF-ADDRESSED STAMPED ENVELOPE TO:
River Tennis Club, % Mrs. E. G. Black, 2837 E. Park Place, Milwaukee 11, Wisconsin

...and Lecture Schedules

H. G. Boren, M.D.
Houston, Tex.

TUESDAY
8:00 p.m.—Fireside Conference

WEDNESDAY
10:30 a.m.—Internal Medicine
11:00 a.m.—Discussion, Internal Medicine

D. T. Carr, M.D.
Rochester, Minn.

TUESDAY
3:45 p.m.—Internal Medicine
8:00 p.m.—Fireside Conference

WEDNESDAY
9:30 a.m.—Panel, Internal Medicine
11:00 a.m.—Discussion, Internal Medicine

Tague Chisholm, M.D.
Minneapolis, Minn.

WEDNESDAY
10:30 a.m.—General Practice
12:15 p.m.—Roundtable Luncheon
2:00 p.m.—Pediatrics

G. D. Davis, M.D.
Rochester, Minn.

THURSDAY
3:45 p.m.—Radiology
7:00 p.m.—Radiology Society Dinner

M. E. Davis, M.D.
Chicago, Ill.

WEDNESDAY
12:15 p.m.—Roundtable Luncheon
2:30 p.m.—General Practice

E. J. DeCosta, M.D.
Chicago, Ill.

TUESDAY
2:00 p.m.—OB-GYN
3:45 p.m.—Panel, OB-GYN

Benjamin Felson, M.D.
Cincinnati, Ohio

THURSDAY
11:30 a.m.—General Session
12:15 p.m.—Roundtable Luncheon
2:00 p.m.—Radiology

Mr. H. W. Ginty
Fort Wayne, Ind.

TUESDAY
12:15 p.m.—Roundtable Luncheon
2:00 p.m.—Psychiatry

J. R. Heller, M.D.
New York City

WEDNESDAY
11:00 a.m.—General Practice
12:15 p.m.—Roundtable Luncheon

Jerome Hilger, M.D.
St. Paul, Minn.

THURSDAY
2:45 p.m.—Ophthal.-Otolaryn.

R. C. Horn, Jr., M.D.
Detroit, Mich.

TUESDAY
12:15 p.m.—Roundtable Luncheon
2:00 p.m.—Pathology
3:45 p.m.—Clinic, Pathology

H. L. Israel, M.D.
Philadelphia, Pa.

TUESDAY
2:00 p.m.—Internal Medicine
4:05 p.m.—Panel, Internal Medicine
8:00 p.m.—Fireside Conference

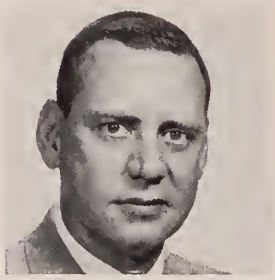
WEDNESDAY
11:00 a.m.—Discussion, Internal Medicine

(Picture Unavailable)

A. J. Kanter, M.D.
Chicago, Ill.

WEDNESDAY

3:45 p.m.—General Practice



Kenneth Keown, M.D.
Columbia, Mo.

THURSDAY

11:00 a.m.—General Session

12:15 p.m.—Roundtable Luncheon

2:30 p.m.—Anesthesiology

G. B. Logan, M.D.
Rochester, Minn.

WEDNESDAY

12:15 p.m.—Roundtable Luncheon

2:30 p.m.—Pediatrics

D. B. Radner, M.D.
Chicago, Ill.

TUESDAY

2:30 p.m.—Internal Medicine
4:05 p.m —Panel, Internal Medicine
8:00 p.m.—Fireside Conference

WEDNESDAY

9:30 a.m.—Panel, Internal Medicine

K. L. Roper, M.D.
Chicago, Ill.

THURSDAY

10:30 a.m.—General Session

2:00 p.m.—Ophthal.-Otolaryn.

J. L. A. Roth, M.D.
Philadelphia, Pa.

WEDNESDAY

10:00 a.m.—General Practice

12:15 p.m.—Roundtable Luncheon

2:00 p.m.—Gastroenterology

R. C. Schneider, M.D.
Detroit, Mich.

WEDNESDAY

11:30 a.m.—General Practice

12:15 p.m.—Roundtable Luncheon

2:00 p.m.—Orthopedic Surgery

S. H. Sturgis, M.D.
Boston, Mass.

TUESDAY

12:15 p.m.—Roundtable Luncheon

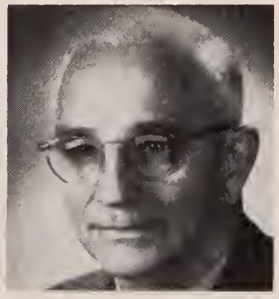
2:30 p.m.—OB-GYN

3:45 p.m.—Panel, OB-GYN

F. H. Van Bergen, M.D.
Minneapolis, Minn.

THURSDAY

2:00 p.m.—Anesthesiology



O. H. Wangensteen, M.D.
Minneapolis, Minn.

THURSDAY

12:15 p.m.—Roundtable Luncheon

2:45 p.m.—Surgery

ADMISSION OF NONMEDICAL PERSONNEL

Students • Nurses • Technicians

All nonmedical personnel will be admitted to the Exhibit Hall and the Lecture Halls only:

1. IF CERTIFIED BY A MEMBER
2. ONE OF THESE TWO DAYS:
   Wednesday, May 3: after 3 p.m.
   Thursday, May 4: 9 a.m. to 3 p.m.

Exhibits close at 3:30 p.m. Thursday, May 4

Faculty Lecturers

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL, Madison

F. J. ANSFIELD, M.D.: Assist. Prof., Cancer Research Hosp.

J. H. BARBOUR, M.D.: Assist. Prof., Anesthes.

J. Z. BOWERS, M.D.: Dean, Med. School; Prof., Medicine

H. A. DICKIE, M.D.: Prof., Medicine

J. H. FLINN, M.D.: Assist. Prof., Medicine; Dir., Student Health

W. H. JAESCHKE, M.D.: Prof., Medicine (Clin. Path.), Dir. Lab. Surgical Path.

S. A. M. JOHNSON, M.D.: Prof., Medicine (Dermatology)

J. H. JUHL, M.D.: Assoc. Prof. Radiol.

Wm. KIEKHOFER, M.D.: Assist. Prof., Obstetrics & Gynecology

G. C. MUELLER, M.D.: Prof., Oncology

B. M. PECKHAM, M.D.: Prof. & Chrm., Ob. & Gyn.

J. R. PELLETT, M.D.: Proj. Assoc., Cancer Res. Hosp.

K. L. SIEBECKER, M.D.: Assoc. Prof. Anesth.

A. A. SIEBENS, M.D.: Assoc. Prof., Pediatrics; Med. Dir., Respiratory & Rehabilitation Center

G. H. VOGT, M.D.: Clin. Instr., Orthopedic Surgery

W. P. YOUNG, M.D.: Assoc. Prof., Surgery

C. W. COTTERMAN, Ph.D.: Prof., Medicine (Genetics)

MARQUETTE UNIVERSITY SCHOOL OF MEDICINE, Milwaukee

D. P. BABBITT, M.D.: Clin. Instr., Radiology

L. G. CAREY, M.D.: Assist. Instr., Surgery

G. E. COLLENTINE, JR., M.D.: Assist. Clin. Prof., Surgery

C. J. FINN, M.D.: Assist. Clin. Prof., Otolaryngology

DONALD GREIFF, Sc.D.: Prof., Pathology

J. D. HURLEY, M.D.: Assist. Prof., Surgery

J. J. JACOBY, M.D.: Prof. & Chrm., Anesthesiology

H. J. KANIN, M.D.: Asst. Clin. Prof., Medicine

J. J. LEVIN, M.D.: Assoc. Prof., Medicine

R. T. McCARTY, M.D.: Assoc. Clin. Prof., Surgery

F. J. MILLEN, M.D.: Assoc. Clin. Prof., Neurology

F. D. MURPHY, M.D.: Clin. Prof., Medicine

P. B. O'NEILL, M.D.: Clin. Instructor, Medicine

A. J. QUICK, M.D.: Prof. & Chrm., Biochemistry

R. A. SCHMIDT, M.D.: Clin. Instr., Anesthes.

J. SHAIKEN, M.D.: Assoc. Clin. Prof., Medicine

J. M. SULLIVAN, M.D.: Assoc. Clin. Prof., Surgery

W. D. THOMAS, M.D.: Asst. Clin. Prof., Surgery

E. S. TURRELL, M.D.: Prof. & Chrm., Psychiatry

B. A. WAISBREN, M.D.: Assist. Clin. Prof., Medicine

W. WEISEL, M.D.: Assoc. Clin. Prof., Surgery

W. J. WOLOSCHEK, M.D.: Clin. Instr., Surgery

S. K. WYNN, M.D.: Assist. Clin. Prof., Plastic & Reconstructive Surgery

Annual Dinner

WEDNESDAY—MAY 3

BALLROOM—HOTEL SCHROEDER

RECEPTION: 6:15 **DINNER: 7:15**

Fun and Informal! With direction from President Sorenson a new approach to the Annual Meeting program has been developed so that a lighter, more informal atmosphere will prevail. Highlight of the program will be a musical comedy skit. There will be no major speech for the evening.

Music: Steve Swedish and his Band.
Dancing: During Dinner and from 10:00 p.m. to 11:30 p.m.
Light Entertainment: A clever and tuneful skit.

"MY FAIR SURGEON"

Music by two well-known figures:
Lerner & Lowe!
Lyrics by a "sleeper":
Frank J. Cerny, M.D., Fond du Lac

A really high class satire on "My Fair Lady" which has a medical theme. Produced and performed by members of the Woman's Auxiliary to the Fond du Lac County Medical Society.

Starring: *Mrs. James Habermann*, Denver (Formerly of Fond du Lac . . . whom we are flying in for the occasion!)

Left to right: Mrs. Hans Hagel, Mrs. Howard Mauthe, Mrs. L. J. Keenan, and Mrs. R. W. Schroeder.

Make up a party and join in on the fun . . . this will be a time for relaxation and laughter! $7.00 per person (including refreshments at President's Reception). A bargain, so bring along your wife and make your reservations at the same time you make reservations for noon luncheons.

MRS. S. H. AMBROSE
State President

MRS. J. HOWARD JOHNSON
State President-elect

MRS. HARLAN ENGLISH
National President-elect

ELIZABETH COMSTOCK, M.D.
Honored Guest

Highlights

ANNUAL MEETING PROGRAM OF THE

Woman's Auxiliary

TUESDAY, MAY 2

3:00 p.m.—REGISTRATION: Main lobby, Hotel Schroeder; 5:30 p.m.—Get-acquainted Hour: Colonial Room, Wisconsin Club; 6:30 p.m.—Board of Directors' dinner and meeting: MacArthur Room, Wisconsin Club (dress informal), those who attend: state officers, state chairmen, councilors, county presidents and presidents-elect, past state presidents, past national president, and honored guests.

WEDNESDAY, MAY 3

8:00 a.m.—REGISTRATION: Main lobby, Hotel Schroeder; 8:30–9:30 a.m.—Continental Breakfast: Loraine Room, Hotel Schroeder.

9:45 a.m.—FORMAL OPENING of the thirty-third meeting of the Woman's Auxiliary to the State Medical Society of Wisconsin: Loraine Room, Hotel Schroeder, Mrs. S. H. Ambrose, Whitewater, president, presiding.

- 12:30 p.m.—LUNCHEON: Crystal Ballroom, Hotel Schroeder. Honoring Mrs. Harlan English, Danville, Illinois, President-elect of the Woman's Auxiliary to the American Medical Association, and Elizabeth Comstock, M. D., Arcadia, Wisconsin's oldest living practicing woman physician.

  A Message from National: "The Happy Lot of a Doctor's Wife" by Mrs. Harlan English.

After the luncheon and program, there'll be time to: shop, visit exhibits at Auditorium, cup of coffee, conducted one-hour tour of the Milwaukee Art Institute, game of cards in the Loraine Room of Hotel Schroeder, visit Auxiliary's hospitality room, 1430, at Hotel Schroeder to chat with friends and meet out-of-state guests and relax.

6:30 p.m.—RECEPTION of the President of the State Medical Society: East Room, Hotel Schroeder.

- 7:15 p.m.—ANNUAL DINNER, program and dance: Crystal Ballroom, Hotel Schroeder.

  "My Fair Surgeon" presented by members of the Woman's Auxiliary to the Fond du Lac County Medical Society, under the direction of F. J. Cerny, M. D., Fond du Lac.

THURSDAY, MAY 4

8:00 a.m.—REGISTRATION; 8:30–9:30 a.m.—Continental Breakfast; 9:45 a.m.—SECOND BUSINESS SESSION including memorial service, courtesy resolutions, report of nominating committee, election of officers, election of nominating committee for 1962, and report of registration.

- 12:30 p.m.—LUNCHEON AND STYLE SHOW: Milano Room, Milwaukee Athletic Club. Honoring members of the Woman's Auxiliary to the Student American Medical Association.

  Installation of officers, presentation of president's pin and the style show under the direction of members of the Milwaukee Chapter of the Auxiliary to the Student American Medical Association. Nurses' uniforms, then and now, dating from 1859 to 1961, will be modeled by Wisconsin Auxiliary members. (Costumes courtesy J. C. Penney Company)

RESERVATION FORMS FOR

Roundtable Luncheons • Annual Dinner

NOTE: Attendance Limited! Please List 3 Choices for each of the days you make reservations. List in order of preference. $2.75 per luncheon, including gratuities.

TUESDAY, MAY 2 (See page 225 of March issue for listing)

IMPORTANT: Those making reservations for the Marquette and U. of W. Alumni luncheons please make your reservations as indicated and DO NOT INCLUDE WITH THIS RESERVATION.

1. HORN: HISTOLOGIC DIAG. OF THYROID CANCER
2. STURGIS: TREATMENT OF PRIMARY DYSMENORRHEA
3. GINTY: THE MD AND VIOLATION OF THE LAW

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice: _____

WEDNESDAY, MAY 3 (See page 227 of March issue for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. ROTH: POST CHOLECYSTECTOMY SYNDROME
2. SCHNEIDER: THE HYPERTROPHIC ARTHRITIC WITH NEUROLOGICAL SIGNS
3. CHISHOLM: INTESTINAL OBSTRUCTION IN THE NEWBORN
4. LOGAN: DIFFERENTIAL DIAG. OF ASTHMA IN CHILDHOOD
5. HELLER: WHAT CAN BE DONE IN REDUCTION OF CANCER DEATHS
6. JOHNSON: ITCHING
7. JACOBY: ANESTHETIC PROBLEMS OF THE SMALL HOSPITAL
8. DAVIS: INDUCTION OF LABOR
9. McCARTY: OFFICE PROCTOLOGY

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice: _____

THURSDAY, MAY 4 (See page 229 of March issue for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. WANGENSTEEN: SURGICAL ASPECTS OF ALIMENTARY TRACT CA
2. FELSON: SPLENOPORTOGRAPHY
3. KEOWN: ARRHYTHMIAS ASSOCIATED WITH ANESTHESIA
4. PECKHAM & KIEKHOFER: UTERINE BLEEDING
5. E.E.N.T. LUNCHEON
6. MURPHY: MANAGEMENT OF RESISTANT CONGESTIVE HEART FAILURE
7. COLLENTINE, CONWAY, & WOLOSCHEK: NOTHING ON BURNS

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice: _____

ANNUAL DINNER, Wed., May 3

DANCING—FLOOR SHOW
SHORT SPEECHES—COCKTAILS

$7.00 PER PERSON (Including Gratuities)

Number Luncheon Tickets ($2.75 each) . . . . . _____ for $_____

Number Annual Dinner Tickets ($7.00 each) . . _____ for $_____ TOTAL $_____

Make Check Payable to: STATE MEDICAL SOCIETY OF WISCONSIN

NAME_____ STREET_____ CITY_____

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You save more than money with U.S. Savings Bonds

20th ANNIVERSARY 1941 1961

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ASHLAND-BAYFIELD-IRON

Dr. Ruth E. Dunham of the United States Public Health Service addressed the members of the Ashland–Bayfield–Iron County Medical Society at their meeting March 10. She explained a proposed medical survey to be held in Bayfield County in April. The society approved the survey as outlined.

Dr. H. V. Sandin, Ashland, was re-elected president; *Dr. C. A. Grand*, Ashland, secretary-treasurer, and *Dr. J. M. Jauquet*, Ashland, delegate.

BROWN

Sixty physicians attended the February 10 meeting of the Brown County Medical Society in Green Bay. They heard Dr. John M. Dorsey, professor of surgery at Northwestern University Medical School, talk on "The Surgical Treatment of Carcinoma."

Dr. Robert T. Schmidt, Green Bay, discussed a Curative Workshop Advisory Committee meeting held February 1. The following statement on curative workshops was passed by the society:

"In order to better facilitate the use of the Curative Workshop in total rehabilitation of patients with a physical disability, permission is requested from this medical society to allow the staff of the Curative Workshop to make contact with these patients and then ask permission of the attending physician to carry out prescribed therapy. This is an extension of the current policy of the Curative Workshop in providing services to patients at the Curative Workshop and two of the local hospitals to patients in their own homes and nursing homes. This is now being done in the Speech and Hearing services of the Curative Workshop."

Dr. Patricia Lanier, Kewaunee, gave a report on medical care for the aged, based on her attendance at the White House Conference on Aging.

The meeting was adjourned for 30 minutes so that the members would have an opportunity to watch a television debate on medical care for the aged between Dr. Edward Annis, Miami, Florida, and Walter Reuther.

CHIPPEWA

Members of the Chippewa County Medical Society met in Chippewa Falls February 7 to hear Dr. Nathan Smith, chairman of the Department of Pediatrics, University of Wisconsin Medical School discuss "Hemoglobin and Anemia in Childhood." Twenty-two members attended.

In the business meeting discussion was held on the retirement plan for members of the State Medical Society, the possibility of increased state coverage for welfare, the cost of drugs for welfare patients, and the use of trade names versus generic names for drugs.

DANE

A Dane County Health Fair, to be held in May of 1962, was approved by members of the Dane County Medical Society at a meeting March 14. The fair will be designed to interest young people in careers in medicine and allied fields, and present exhibits relating to all phases of medical activity for general public interest. A special assessment of $15 per member was approved to finance the fair, which will be free to the public. On the committee are *Dr. J. F. McIntosh*, *Dr. Charles A. Doehlert, Jr.* *Dr. Richard J. Botham*, *Dr. Charles K. Kincaid*, and *Dr. P. B. Golden*, all of Madison.

DODGE

The third annual meeting of the Beaver Dam Medical Forum was held at the Rogers Hotel, Beaver Dam, the evening of Monday, February 20.

Dr. H. T. Ransdell, Associate Professor of Surgery at the University of Louisville, Ky., was the guest speaker. His talk was entitled "The Emergency Treatment of Thoracic Trauma." Doctor Ransdell's talk was well received by a large audience, including some of his classmates and several alumni of the University of Louisville School of Medicine.

Beaver Dam Citizen Photo

Members of the Beaver Dam Medical Forum are shown above with the guest speaker, Dr. H. T. Ransdell, Louisville, Ky. (seated right). Others are (seated left to right): Dr. Roger Bender, president of the Forum; Dr. Robert Boock, program chairman; Doctor Ransdell; and (standing left to right) Dr. William Richards, secretary–treasurer; and Dr. Howard Bayley, Forum chairman.

Physicians whose names appear in italic are members of the Society.

The plan for the emergency care of thoracic trauma, as used at the Louisville General Hospital, was outlined. Emphasis was placed on the need for immediate action, including tracheostomy and definitive surgery in the moribund patient. The results of the use of this plan, plus the use of the Barker Apparatus and intensive nursing care, have greatly improved the chances of life in the moribund accident victim.

The Beaver Dam Medical Forum is an organization of local and area physicians. The purpose of the group is to improve the medical care of the patient, by greater dissemination of recent advances in medicine. The doctors meet nine times a year, with one of the meetings featuring an out-of-state speaker. The annual meeting is a dinner meeting, and is open to all doctors of medicine who might be interested in the program to be presented.

DOOR-KEWAUNEE

The January meeting of the Door–Kewaunee County Medical Society was held January 24 at Algoma. Ernest Mercier of the Green Bay social security office was the speaker. He also showed a film entitled "The Disability Decision."

New officers of the society are *Dr. Jeffrey Brooks*, Sturgeon Bay, president; *Dr. Charles Stiehl*, Algoma, vice-president and *Dr. Patricia F. Lanier*, Kewaunee, secretary–treasurer. *Dr. Weldon Sheets*, Sturgeon Bay, was named delegate to the State Medical Society.

FOND DU LAC

Dr. A. M. Hutter, Fond du Lac, presented a report on the White House Conference on Aging before the January 26 meeting of the Fond du Lac County Medical Society. Members also discussed proposals for a memorial to the late *Dr. Stephen Gavin.*

GRANT

Dr. Richard McKay and Dr. Louis Alt, both of Dubuque, Iowa, discussed "Chemotherapy in Carcinoma and Related Diseases" at the December meetting of the Grant County Medical Society.

In elections held at the meeting *Dr. Leo E. Becher*, Lancaster, was named president; *Dr. Cedric King*, Cuba City, vice-president; and *Dr. H. W. Carey*, Lancaster, secretary-treasurer. Doctor Carey was elected delegate and *Dr. Charles Steidinger*, Platteville, alternate to the State Medical Society.

GREEN LAKE-WAUSHARA

Members of the Green Lake–Waushara County Medical Society heard *Dr. E. C. Albright*, Madison, talk on "Current Treatment of Hyperthyroidism" at their February 22 meeting. Doctor Albright's appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society. Twelve members attended.

JEFFERSON

Dr. David Cleveland, Milwaukee, discussed "The Injured Cervical Spine—So-Called Whiplash or Cervical Disk Injury" at the February meeting of the Jefferson County Medical Society. His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society.

LA CROSSE

Dr. E. D. Sorenson, Elkhorn, president of the State Medical Society, addressed the La Crosse County Medical Society February 21 on the organization of the state society. *Dr. James C. Fox*, chairman of the Council also explained the functions of the Council.

During the business meeting a committee was appointed to review the current fee schedule, a letter was approved for transmittal to the traffic commissioner urging strict enforcement and support of traffic laws, and a committee was established to study the problem of tuberculin testing of school children. Fifty-four members attended the meeting.

PRICE-TAYLOR

Dr. W. J. Smiles, Ashland, addressed the members of the Price–Taylor County Medical Society in January on the subject of "Hypertensive Cardiovascular Disease." His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society.

RACINE

S. L. Horman, Milwaukee, vice-president of Time Insurance Company, spoke at the February meeting of the Racine County Medical Society. Horman, a member of the Wisconsin Committee for the Aged, compared the two current approaches to the problem of health care for the aged. He endorsed the Kerr–Mills law and urged the physicians to work for the plan. He also spoke on insurance coverage trends.

ROCK

Members of the Rock County Medical Society heard *Dr. F. F. Rosenbaum*, Milwaukee, discuss "Diagnosis and Management of Paroxysmal Cardiac Arrhythmias" at their January meeting.

Doctor Rosenbaum, associate clinical professor of medicine at Marquette University School of Medicine, appeared under sponsorship of the Charitable, Educational and Scientific Foundation of the State Medical Society.

SAUK

The Sauk County Medical Society met March 14 at the Warren Hotel in Baraboo for a dinner and a scientific program. Dr. George Rowe of the University Hospitals, Madison, was the guest lecturer. He discussed "Diagnosis of Congenital Heart Disease." His presence at the meeting was under the auspices of the State Medical Society's Charitable, Educational and Scientific Foundation which coordinates a Speaker's Bureau for county medical societies and district councilor meetings.

SHAWANO

Dr. H. C. Marsh, Shawano, was elected president of the Shawano County Medical Society at the group's January meeting. *Dr. H. F. Laufenburg*, Shawano, was named vice-president and *Dr. A. J. Sebesta*, Shawano, secretary.

TREMPEALEAU-JACKSON-BUFFALO

Dr. Charles M. Ihle, Eau Claire, spoke at the January meeting of the Trempealeau–Jackson–Buffalo County Medical Society on sprains of the ankle and knee. During the business meeting discussion was held on a fee schedule.

WINNEBAGO

Members of the Winnebago County Medical Society heard Dr. Lionel Bernstein, from Hines Hospital, Illinois, discuss "Endocrine Control of Renal Function" at their February meeting. The group met at the Athearn Hotel in Oshkosh.

VERNON

Dr. Stuart Roberts, of the Illinois Research Hospital, Chicago, Illinois, discussed "Dissemination of Cancer Cells in the Blood" at the February meeting of the Vernon County Medical Society.

During the business meeting the members voted to donate $150 to the Student Loan Fund of the Charitable, Educational and Scientific Foundation, discussion was held on contributing all immunization clinic fees for physicians to the society for charitable works. Eighteen members attended the meeting.

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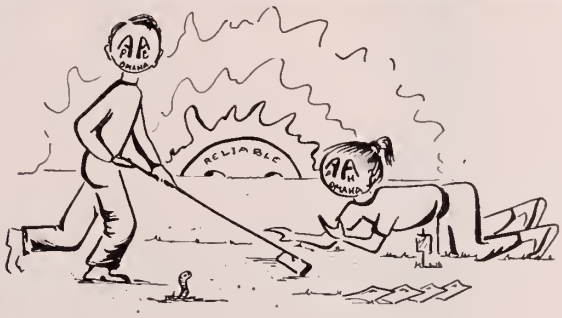

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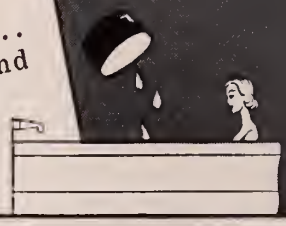

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Milwaukee Urological Society

At the recent annual meeting of the Milwaukee Urological Society, the following officers were elected for 1961:

President—*Dr. John W. Kearns,* Milwaukee
Secretary-Treasurer—*Dr. John G. Frisch,* Milwaukee

Wisconsin Society of Pathologists

The Wisconsin Society of Pathologists has announced the election of the following officers for 1961:

President—*Dr. Joseph M. Lubitz,* Milwaukee
President-elect—*Dr. Frank J. Glassy,* Marshfield
Vice-president—*Dr. David J. Carlson,* Milwaukee
Secretary—*Dr. Robert S. Haukohl,* Milwaukee
Treasurer—*Dr. Chesley P. Erwin,* Milwaukee

The Society will hold its annual summer meeting on June 24 at the State Laboratory of Hygiene, Madison. The morning session will be devoted to papers on clinical pathology by members of the Society. The afternoon session will be a tissue seminar on "Diseases of the Central Nervous System, Non-neoplastic" moderated by Dr. Andrew E. Cyrus, Jr., assistant professor of pathology (neuropathology), Marquette University School of Medicine, and consultant in neuropathology, Milwaukee County General Hospital and Veterans Administration Hospital, Wood.

A limited number of slide sets are available at $10 per set on a first-come, first-serve basis. Direct all requests and inquiries to Robert S. Haukohl, M.D., Secretary, 561 North 15th Street, Milwaukee, Wisconsin.

Physicians whose names appear in italic are members of the Society.

Milwaukee Oto-Ophthalmic Society

Dr. Christopher Dix discussed "Malignancies about the Face; Their Treatment" at the March 28 meeting of the Milwaukee Oto-Ophthalmic Society held at the University Club of Milwaukee. Doctor Dix is associate professor of plastic and oral surgery at Marquette University School of Medicine and Dentistry.

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NEWS OF WISCONSIN PHYSICIANS

Doctor Tverberg Is Cancer Director

Dr. M. S. Tverberg, Mauston, has been appointed to the Board of Directors of the Juneau County Unit of the Wisconsin Division, American Cancer Society. The appointment was announced at the January meeting of the unit.

Dr. Pellicer Establishes Brillion Practice

Dr. Joseph G. Pellicer, Merrill, has opened a medical practice in Brillion. He replaces *Dr. Rafael Barajas* who has relocated at Waupun.

Dousman Welcomes Doctor Haugh

The Dousman business men sponsored a banquet February 14 to welcome Dr. Thomas Haugh to the community. *Dr. J. S. Hirschboeck*, Dean of the Marquette University School of Medicine, was the principal speaker at the banquet.

Doctor Henke Joins Staff At Eau Claire

Dr. Frederick W. Henke was recently named a member of the Sacred Heart Hospital medical staff at Eau Claire. Doctor Henke, a radiologist, joins *Dr. Ralph C. Frank* and *Dr. H. M. Aitkin* on the radiological staff of the hospital. A general practitioner in Shawano from 1946 to 1957, he received his specialty training at the University of Minnesota Medical School.

Doctor Rogers Joins Staff at Wood

Dr. R. M. Rogers, Whitehall, left that community in February to accept a position on the medical staff at Veterans Administration Hospital, Wood. He had practiced in Whitehall since March 2, 1960, and was at Tigerton prior to that time.

Doctor Donnell Radiologist At Kenosha

Dr. William S. Donnell has been named associate radiologist at Kenosha Hospital. A graduate of Marquette University School of Medicine in 1950, Doctor Donnell interned at Milwaukee County Hospital. He has practiced at Veterans Administration Hospital, Wood; St. Mary's Hospital, Racine; and Aliquippa Hospital, Aliquippa, Pennsylvania, before coming to Kenosha.

Doctor Stone Joins Cuba City Clinic

Dr. Mildred Stone, Madison, has joined the staff at Cuba City Medical Center Clinic. Doctor Stone is a general practitioner with a special interest in allergies and pulmonary diseases.

Brown County Pharmacists Hear Dr. Nadeau

Dr. George Nadeau, member of the State Medical Society's Committee on Federal Legislation, spoke at the February 9 meeting of the Brown County pharmacists. He discussed legislation and public health.

Dr. Potter Addresses Medical Alumni

Van R. Potter, Ph. D., assistant director of McArdle Laboratory for Cancer Research at the University of Wisconsin, talked before the University of Wisconsin Medical Alumni at the University Club in Milwaukee on February 10. *Dr. John Z. Bowers*, Dean of the University of Wisconsin Medical School, also appeared before the group.

Dr. Halleck Named Psychiatric Chief

Dr. Seymour L. Halleck has been named chief of the psychiatric field service of the State Division of Corrections, which serves the inmates of state reformatories and prisons. He succeeds the late Dr. Peter Bell. Doctor Halleck was a member of the faculty at the University of Wisconsin Medical School prior to joining the state welfare administration about a year ago.

Dr. Graiewski Discusses Civil Defense

Dr. S. J. Graiewski, Oshkosh, discussed civil defense at a meeting of the Woman's Auxiliary to the Winnebago County Medical Society in January.

Fond du Lac Club Heard Dr. Belcher

Dr. C. H. Belcher, Oshkosh, was guest speaker before the Men's Club of St. Peter's Lutheran Church in Fond du Lac in February. Doctor Belcher is superintendent of Winnebago State Hospital, and explained plans for a treatment facility to be established there.

New Physician Arrives In Redgranite

Dr. Erich Schmidt has established a practice in Redgranite, Waushara County. A native of Germany, Doctor Schmidt comes to Wisconsin from Winnipeg, Canada, where he has been practicing for the past four years.

Addresses Pierce–St. Croix Pharmacists

Dr. H. A. Dasler, Amery, a member of the State Medical Society's Committee on Federal Legislation, spoke before the Pierce–St. Croix pharmacists in February. Legislation and public health were the topics discussed.

Dr. Hildebrand Addresses Oshkosh Group

"Aims of opposing health and welfare programs are the same, but there is a fundamental difference in philosophy between President Kennedy's program and that supported by the American Medical Association," *Dr. William B. Hildebrand*, Menasha, told members of the Winnebago Chapter, Wisconsin Academy of General Practice, at their charter night meeting in February. Explaining the differences

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Physicians whose names appear in italic are members of the Society.

between the two philosophies, Doctor Hildebrand also pointed out the high cost of the proposed Federal plan.

Medical Assistants Hear Doctor Buran

"The Challenge of the Cost of Medicine" was the topic presented by Dr. David J. Buran, Oshkosh, at the February meeting of the Winnebago County Medical Assistants.

Dr. Venning Resigns As Health Officer

Dr. J. R. Venning, Fort Atkinson city health officer since 1924, has informed city officials of his resignation. Said the *Jefferson County Union,* "Doctor Venning has felt the pulse of this community for 37 years in his role as health officer. He has kept track of births, illnesses, deaths and other statistics."

Dr. Kroeplin Talks On School Health

Dr. F. C. Kroeplin, Stratford, spoke on school health before parents of students at St. Joseph's Catholic School in that community in February. He talked on health programs and problems in the Stratford schools.

Doctor Limberg Honored

Dr. Allen Limberg, Glenwood City, has been named to Lakeland College's athletic Hall of Fame. He was an outstanding athlete at the college in the early 1940's. A general practitioner, Doctor Limberg is mayor of his city and also serves as St. Croix County coroner.

Physicians Participate In Panel Discussion

A panel discussion on "Meeting the Needs of our Aging Population" was presented at the February meeting of the Neenah–Menasha branch of the American Association of University Women. Moderator of the panel was *Dr. Patricia Lanier,* Kewaunee, and *Dr. William Hildebrand,* Menasha, was a member of the panel.

Dr. Stuessy Named Outstanding Citizen

The Brodhead Junior Chamber of Commerce has named *Dr. M. W. Stuessy* as that community's outstanding senior citizen. He was cited for his efforts to improve the educational system and his medical service to the community. Doctor Stuessy has served as president for the board of education for 13 years.

Retardation Council Hears Dr. Kaufman

Dr. Melvin E. Kaufman, Madison, assistant professor of pediatric psychiatry, University of Wisconsin Medical School, was featured speaker before the Madison Area Retardation Council, Inc., in January. His topic was "The Hyperactive Mentally retarded Child."

Doctor Epstein Awarded Research Grant

Dr. Stephan Epstein, Marshfield dermatologist, has been awarded a $31,430 research grant to study light sensitivity in animals. The grant was made by the National Institutes of Health. Doctor Epstein has been engaged in the study of sensitivity to light and allergy to sunlight for many years.

Doctor Smith Joins Monroe Clinic

Dr. Robert Smith, a specialist in ophthalmology, has joined The Monroe Clinic. He comes to Monroe from Rockford, Illinois.

Two Physicians Join Waupun Clinic

Dr. Rafael Barajas, formerly of Brillion, has joined the Waupun Clinic. A graduate of the University of Mexico Medical School, Doctor Barajas interned at St. Mary's Hospital, Madison.

Expected to join the clinic July 1 is Dr. Martin F. Petereit, a graduate of the University of Nebraska Medical School, who is presently completing his residency in general surgery at the Veterans Hospital, Fargo, North Dakota.

Doctor Bill Establishes Practice

Dr. Kenneth C. Bill, Elkhorn, has announced that he will establish a private practice in the community on May 1. Doctor Bill is presently associated with the Elkhorn Clinic.

Dr. Windsor Speaks On Tetanus Immunization

Dr. Richard B. Windsor, Sheboygan, urged employers in that community to undertake a company-wide tetanus immunization program in a January speech before the Sheboygan Safety Council. "The mortality rate among people contracting the disease in 1961 is exactly the same as it was in 1930," Doctor Windsor told the audience. "We can guard against its occurring through immunization, but once it occurs about half of the persons contracting it will die."

Doctor Windsor urged the employers to set up mass injection programs in their plants. He cited one death in the area in 1960 and three cases in 1959. "The cost of even one of these cases would buy hundreds of the safe tetanus toxoid injections, he pointed out.

Business Women Hear Doctor Berg

Dr. Mary C. Berg, Madison psychiatrist, spoke at a dinner meeting of the Madison Business and Professional Women's Club in February.

Rotarians Honor Dr. Barry At Sun Prairie

Dr. H. J. Barry, Sun Prairie, was honored in January by the Sun Prairie Rotary Club as outstanding senior citizen of the community. Doctor Barry practiced in Sun Prairie from 1903 until 1925, expect for World War I service. He then served with the Veterans Administration, returning to Sun Prairie when he retired in 1949.

Dr. E. V. Brumbaugh, retired West Allis Health Commissioner, died January 12, 1961, at the age of 83.

Born November 17, 1877, in Memphis, Missouri, Doctor Brumbaugh was a 1913 graduate of Marquette University School of Medicine. He joined the Milwaukee health department in 1914 and four years later became director of the Wisconsin Anti-Tuberculosis Association. In 1920 he became deputy commissioner of the Milwaukee Health department and in 1922 became health officer in Madison. He returned to Milwaukee in 1925 as deputy commissioner and in 1942 became health commissioner of West Allis. He retired in 1958.

Doctor Brumbaugh was a member of the Milwaukee County Medical Society and the American Medical Association until his retirement, and an associate member of the State Medical Society of Wisconsin. He served his county society as a member of its Public Health Committee.

Surviving are his widow, a son, James, of Minneapolis, Minnesota, and a daughter, Betty, of Maywood, Illinois.

Dr. Harry T. Callahan, a general practitioner in Spencer for 37 years, died February 1, 1961, at the age of 64.

Born December 5, 1896, in Merrill, Wisconsin, Doctor Callahan was a 1920 graduate of Marquette University School of Medicine. Following internship at St. Joseph's Hospital in Marshfield, he established his practice in Lewiston, Minnesota. In 1923 Doctor Callahan moved to Spencer where he practiced until entering military service in 1942. After serving as an Army medical officer until February, 1944, he returned to Spencer where he practiced until the time of his death.

Doctor Callahan was a Soo Line physician and surgeon and was licensed in the state of Minnesota. He was a member of the American Legion and was buried with military rites.

Doctor Callahan was a member of the Marathon County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow and a son.

Dr. Eldon L. Watson, Ripon physician for 22 years, died February 3, 1961, at the age of 65.

Born January 20, 1896, in Poynette, Doctor Watson was a 1930 graduate of the University of Wisconsin Medical School. After internship at Methodist Hospital in Madison, he established his practice in Columbus, remaining there until 1938 when he moved to Ripon.

Doctor Watson was a World War I veteran, serving as a pilot. He served as public health officer for the city of Ripon and was a member of Selective Service Board Number 2 in Fond du Lac County during World War II.

An ardent golfer, Doctor Watson was a member of the Wisconsin Medical Golf Association and served on its board of directors. In addition to his medical degree, Doctor Watson also held a degree in agricultural engineering from the University of Wisconsin.

He was a member of the Fond du Lac County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors are his widow, a son, Michael Watson, of Ripon, and a daughter, Mrs. T. J. Wissing, Waukegan, Ill.

Dr. Andrew J. Weber, Milwaukee, died February 5, 1961, at the age of 81. Doctor Weber was a general practitioner with a special interest in surgery.

Born March 5, 1880, in the town of Erin, Washington County, he was a 1907 graduate of the Wisconsin College of Physicians and Surgeons. After internship at St. Joseph's Hospital, he practiced in Milwaukee until the time of his death. He was a veteran of World War I, serving in the Army Medical Corps.

Doctor Weber was a member of The Medical Society of Milwaukee County, a life member of the State Medical Society of Wisconsin, and a member of the American Medical Association. He was a fellow of the Wisconsin Academy of Surgery, and a member of the Central States Society of Industrial Medicine and Surgery.

Surviving are his widow and two daughters.

Dr. Frank J. Kozina, Milwaukee, died February 10, 1961, at the age of 59. Doctor Kozina was a general practitioner with a special interest in industrial medicine.

Born February 22, 1901, he attended Marquette University School of Medicine, receiving his medical degree in 1926. After internship at St. Mary's Hospital in Milwaukee, he established his practice in that community. In addition to his general practice, he served as medical director for Cudahy Brothers Co., Cudahy, Wisconsin.

Doctor Kozina was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, and the American Academy of General Practice.

Survivors include his widow, a son, Dr. Thomas J. Kozina, Milwaukee, and three daughters, Miss Mary Kozina, Mrs. Barbara Redovich and Miss Carol Kozina.

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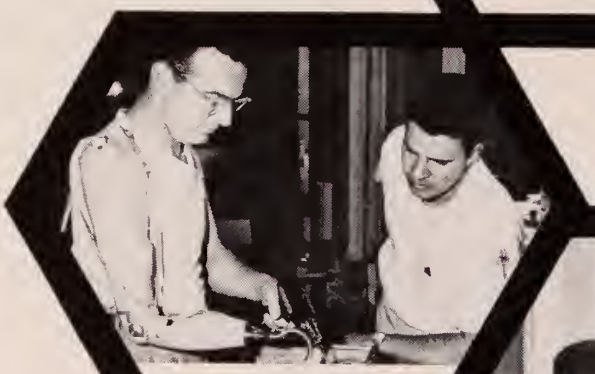

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Director

Cancer Researcher Symposium Lecturer

A technique for tricking cancer cells into embracing chemical compounds that make them highly sensitive to x-rays was described by a University of Wisconsin cancer researcher at a symposium at Houston, Texas, on February 23.

Though human cancer cells were used in his experiments, Dr. Waclaw T. Szybalski cautioned that much work lies ahead before his method could be used to treat human cancer victims. Doctor Szybalski outlined his method at a University of Texas symposium on fundamental cancer research. He told of research done over the past two years at the UW's McArdle Memorial Laboratory under a National Cancer Institute grant.

The experiments Doctor Szybalski described involved chemical changes in cell DNA, the cell's most important genetic material and the chemical carrier of hereditary information. The alterations in the cell's "thread of life"—DNA—were achieved by a substitution of chemicals while the cancer cells were growing and chemically building up DNA.

With more investigation, Doctor Szybalski said, the findings might provide the basis for a new method of cancer treatment for those kinds of cancer which are affected by radiation.

Aside from the possible future practical applications, he said, the use of this halogenated DNA might open up long-range possibilities for explaining the way in which DNA operates, which is a long-standing scientific mystery. Part of this large question involves the "tailoring" of hereditary characteristics, a possibility which is not much past the speculation stage at present.

Doctor Szybalski also speculated that halogenated DNA might be a tool in future investigations into some of the mysteries of life, for example, in attempts by man to manufacture life in the laboratory in the form of biologically functional, life-bearing DNA molecules.

Easter Seal Grant to UW

Improved methods of rehabilitating persons crippled as the result of brain injuries will be sought in a new Wisconsin research project financed by the nation's contributors to Easter Seals.

A $6,637 grant presented to the University of Wisconsin Hospitals, Madison, supports the investigation directed by Dr. Francis M. Forster, chairman of the Department of Neurology. The grant is the third to be presented by the Easter Seal Research Foundation, Chicago, to the university.

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Blood Vessel Surgery, One Week May 15
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General Surgery, One Week, May 8
General Pediatrics, Two Weeks, May 1
Advanced Electrocardiography, One Week, June 19
General Practice Review, One Week, May 22
Neuromuscular Diseases of Children, Two Weeks, June 12
Hematology, One Week, June 12
Gynecology, Office & Operative, Two Weeks, June 12
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MEDICAL MEETINGS—POSTGRADUATE COURSES

Minnesota State Medical Meeting

The Committee on Scientific Assembly of the Minnesota State Medical Association takes pleasure in announcing the general scientific program highlights of its 108th Annual Meeting, May 22, 23 and 24, in the St. Paul Municipal Auditorium.

This year's program has been planned to feature presentations by representatives of the various medical specialties in Minnesota.

In addition, a number of nationally renowned guest lecturers have been invited to participate in the 1961 scientific program.

Program highlights for Monday, May 22, include the Minnesota Academy of Pediatrics lecture given by Nathan J. Smith, M.D., Madison, Wisconsin; the Russell D. Carman Memorial Lecture, C. Allen Good, M.D.., Rochester, Minnesota; and the Arthur H. Sanford Lecture in Clinical Pathology by Charles Heidelberger, Ph.D., Madison, Wisconsin.

On Tuesday, May 23, the opening event will feature a Review of Major Categories of Edema.

On Wednesday, May 24, the Business Side of the Medical Profession will be highlighted.

For additional details, write to the Committee on Scientific Assembly, Minnesota State Medical Association, 496 Lowry Medical Arts Building, St. Paul 2, Minnesota.

Illinois State Medical Meeting

The Illinois State Medical Society will hold its annual meeting at the Hotel Sherman, Chicago, May 14–18.

The scientific program will get under way on Monday and continue through Thursday.

Dr. John B. Reckles of the department of psychiatry, Duke University Medical Center, Durham, N. C., will present "The Facts of Life in the Future of Medicine."

"Human Factors in Jet and Space Flight" will be the subject of the Oration in Medicine by Lt. Col. Charles A. Berry, Aerospace Medicine Division, USAF. The Oration in Surgery will be given by Dr. John Rock, professor emeritus of gynecology, Harvard Medical School, who will speak on "Control of Ovulation: Methods, Merits and Demerits.'"

Dr. Walter P. Blount, Milwaukee, is one of the out-of-state invited speakers.

For further information write to Mr. Robert L. Richards, Executive Administrator, Illinois State Medical Society, 360 North Michigan Avenue, Chicago 1.

Trudeau School of Tuberculosis

The Trudeau School of Tuberculosis and Other Pulmonary Diseases will hold its forty-sixth session in Saranac Lake, N.Y., from June 5 to 23. Attendance at the Trudeau School carries with it a thorough review for specialization in pulmonary disease or for work in public health involving tuberculosis.

The enrollment is necessarily limited and therefore application should be made early. A few scholarships are available for those who qualify.

Inquiries should be addressed to the Secretary, Trudeau School of Tuberculosis and Other Pulmonary Diseases, Box 670, Saranac Lake, N. Y.

Minnesota Continuation Courses

Medical continuation courses to be presented at the Center for Continuation Study, University of Minnesota, are as follows:

May 1–3: Ophthalmology for Specialists.
May 8–10: Gynecology for General Physicians.
May 11–13: Surgery for Surgeons.
May 15–19: Proctology for General Physicians.
June 1–3: Office Psychotherapy for General Physicians.
1960–1961 (all year): Cancer Detection for General Physicians.

For further information concerning the above courses, write to the Director, Department of Continuation Medical Education, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14, Minnesota.

Colorado Postgraduate Calendar

May 18–19: Eleventh annual Colorado Intern-Resident Clinics.
June 1–3: Physical Medicine and Rehabilitation for the Clinician.
June 19–21: Obstetrics and Gynecology; "Principles of Human Genetics."
July 10–13: Ophthalmology (Estes Park).
July 27–29: Dermatology for the General Practitioner.
Aug. 7–12: Hepatic Pathology (limited to 24).
Aug. 21–25: Pediatrics—Clinical and Research Advances in Pediatrics and Child Guidance (Estes Park).
Sep. 25–29: Pulmonary Disease Seminar (Fitzsimons General Hospital).
Jan. 7–13, 1962: General Practice Review (Eighth Annual)

The above programs will be held at the University of Colorado Medical Center, Denver, unless otherwise indicated. For further information write to: The Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver 20, Colo.

American College of Chest Physicians

The 27th Annual Meeting of the American College of Chest Physicians will be held at the Commodore Hotel, New York City, Thursday, June 22 through Monday, June 26. A joint session with the Section on Diseases of the Chest of the American Medical Association will be held at the Coliseum, Monday, June 26. The popular Fireside Conferences,

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CONFERENCE CHAIRMAN: H. Kent Tenney, M. D., Madison

A. M.

9:30—REGISTRATION (2nd Floor of Brooks Memorial Union, 2nd Floor Outside of Ballroom)

10:00—WHAT THIS CONFERENCE IS DESIGNED TO ACCOMPLISH: Dr. H. Kent Tenney

10:15—MEDICAL AND NONMEDICAL EVALUATION OF THE GROWING CHILD:

1. **WHAT CAN BE EXPECTED OF THE PHYSICIAN: Reynold A. Jensen, M. D.,** Professor of Psychiatry and Pediatrics, University of Minnesota Medical School, Minneapolis
2. **EDUCATIONAL EVALUATIONS OF MENTAL CAPACITY AND POTENTIAL GROWTH: Eldon Bond, Ph. D.,** Assistant Superintendent of Schools, Milwaukee

11:15—COUNSELING AND PLANNING WITH THE FAMILY:

1. **CLASSIFICATION OF MENTAL LEVELS AND INTERPRETATION TO THE FAMILY: A. A. Lorenz, M. D.,** Eau Claire
2. **EXISTING RESOURCES, AND WHO SHOULD USE WHAT: Leonard J. Ganser, M. D.,** Director, Mental Hygiene Division, Department of Public Welfare, Madison
3. **WHAT THE PARENT EXPECTS OF THE PHYSICIAN: Mr. G. I. Wallace,** Madison

P. M.

12:30—EDUCATIONAL CLASSIFICATION AND EVALUATION OF THE MENTALLY RETARDED CHILD: James McCarthy, Ph. D., Institute for Exceptional Children, Urbana, Ill. **(Tentative)**

1:00—SUMMARY OF CONFERENCE TO THIS POINT: Doctor Jensen (10 minutes)

1:15—LUNCH: A special luncheon is provided at the Cafeteria of Brooks Memorial Auditorium, at $2.00. Tickets will be available at the Registration Desk.

Moderator: E. D. Schwade, M.D., Milwaukee, Chairman of Division on Nervous and Mental Diseases of Commission on State Departments, State Medical Society

2:00—CASE PRESENTATIONS AND DISCUSSION

1. Cases Suitable for Home Care (with Parent Participation)
2. Institutionalized Care (Patients from Southern Colony) Presented by **Henry Veit, M. D.,** Milwaukee, Consultant, Southern Colony, Union Grove

3:40—COFFEE BREAK

4:00—WHAT RESEARCH IS DOING IN THE AREA OF MENTAL RETARDATION.

1. **BIOCHEMICAL RESEARCH AND ITS SIGNIFICANCE TO THE PRACTICING PHYSICIAN: Harry Waisman, M. D.,** Professor of Pediatrics, University of Wisconsin Medical School
2. **GENETIC RESEARCH AND ITS APPLICATION TO MENTAL RETARDATION: David Smith, M. D.,** Associate Professor of Pediatrics, University of Wisconsin Medical School, Madison
3. **EDUCATIONAL RESEARCH: Robert Erdman, Ed. D.,** Associate Professor of Education and Chairman, Department of Exceptional Children, University of Wisconsin—Milwaukee

5:00—WHAT WE HOPE WE HAVE ACCOMPLISHED: Doctors Tenney and Jensen

5:30—ADJOURNMENT

Co-sponsors, with the Charitable, Educational and Scientific Foundation, State Medical Society: Division on Nervous and Mental Diseases, the Wisconsin Council for Mentally Retarded Children, the Wisconsin Association for Mental Health, the Wisconsin Academy of General Practice, the Mental Hygiene Division, Department of Public Welfare, the Bureau of Handicapped Children, Dept. of Public Instruction, The Wisconsin State Board of Health, Marquette University School of Medicine and the University of Wisconsin Medical School.

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1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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also to be a joint session sponsored by both the AMA and the College, will be held at the Commodore Hotel, Monday evening, June 26.

Wisconsin physicians participating in the program are: Dr. John Rankin, Madison; and Drs. Harry Beckman, Clifford H. Kalb, Ross C. Kory, Timothy Murphy, Francis F. Rosenbaum, Oscar A. Sander and John H. Huston, Milwaukee.

North Shore Hospital Seminar

The third seminar in the North Shore Hospital Seminars, 1960–1961, on "Mental Hygiene" will be held at the hospital in Winnetka, Illinois, on Wednesday, May 10, at 8 p.m. The principal speaker will be Dr. John Turner, psychiatrist, Division of Industrial Health, Menninger Foundation, who will discuss "Challenge to the American Economy: Mental Hygiene at Work."

Mediterranean Pediatric Congress

The Second Middle Eastern–Mediterranean Pediatric Congress will convene in Ankara, Turkey, at the Hacattepe Cocuk Hastahanesi from September 6–9. This Congress is being sponsored by the Ministry of Health and Social Assistance, the National Society of Pediatrics and Child Health of Turkey, the Turkish Pediatric Association, the Ankara Child Health Society, and the Research Institute of Child Health of Ankara University. All pediatric physicians and surgeons as well as those engaged in investigative work in any of the fields allied to pediatrics who reside in the Middle East and Mediterranean areas are being invited to participate in the Congress as individuals or representatives of the pediatric societies, or universities, or their governments. Those qualified who reside outside these areas are being welcomed as observers. A program is being planned for wives of members and observers who plan to accompany their husbands. The official languages of the Congress will be English, French and Turkish.

For further information write to the Secretary General of the Congress at the Hacettepe Cocuk Hastahanesi, Ankara, Turkey.

Saranac Lake Symposium

The Tenth Annual Symposium for General Practitioners on Tuberculosis and Other Pulmonary Diseases will be held in Saranac Lake, New York, July 10–14. The session is acceptable for 27 hours of Category 1 credit by the American Academy of General Practice. For further particulars write: Saranac Lake Medical Society, P.O. Box 627, Saranac Lake, New York.

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WISCONSIN CALENDAR COMING EVENTS

1961

Apr. 30: Opening of Museum of Medical Progress, Prairie du Chien.

May 2–3–4: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 11–13: Pathology and Radiology of Chest Diseases, UW postgraduate course, Wisconsin Center Building, Madison.

May 20–21: Wisconsin Association of Blood Banks, meeting, Conway Hotel, Appleton.

May 23: Annual social meeting, Milwaukee Oto-Ophthalmic Society, Univ. Club, Milwaukee.

May 24: Maternal Mortality Institute, St. Mary's Hospital, Wausau.

June 21: Conference on Medical Aspects of Mental Retardation, Brooks Auditorium, Milwaukee.

June 26–30: AMA Annual Meeting, New York, New York.

Aug. 29–31: UW Postgraduate course, Psychiatric symposium, Dr. R. Roessler, chrm., Wisconsin Center Building, Madison.

Sept. 28–30: UW postgraduate course, Anesthesiology, Dr. O. S. Orth, chrm., University Hospitals, Madison.

Oct. 13–14: UW postgraduate course, Psychiatry, Dr. R. Roessler, chrm., Wisconsin Center Building, Madison.

Nov. 16–18: UW postgraduate course, Rehabilitation of Patients with Injuries of the Spinal Cord, Dr. A. Siebens, chrm., Wisconsin Center Building, Madison.

Nov. 28–Dec. 1: AMA Clinical Meeting, Denver, Colorado.

1962

Apr. 5–7: UW postgraduate course, Genetics in Pediatrics, Drs. J. Crow and N. Smith, co-chrm., Wisconsin Center Building, Madison.

Apr. 26–28: UW postgraduate course, Psychosomatic Medicine, Dr. David Graham, chrm., Wisconsin Center Building, Madison.

May 10–11: UW postgraduate course, Orthopedic Surgery, Dr. H. Wirka, chrm., Wisconsin Center Building, Madison.

May 17–19: UW postgraduate course, Anatomy, Physiology and Pathology of the Holocrine, Apocrine and Eccrine Glands, Dr. S. Johnson, chrm., Wisconsin Center Building, Madison.

June 11–15: AMA Annual Meeting, Chicago, Illinois.

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California.

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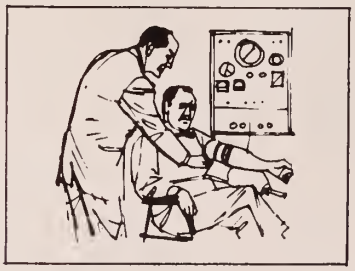

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

NEW BOOKS RECEIVED

BLOOD DISEASES OF INFANCY AND CHILDHOOD

By Carl H. Smith, M.D., Professor of Clinical Pediatrics, Cornell University Medical College, New York, N.Y. C. V. Mosby Co., St. Louis, Missouri, 1960. 572 pages. Price: $17.00.

FRENCH'S INDEX OF DIFFERENTIAL DIAGNOSIS (8th edition)

Edited by Arthur H. Douthwaite, M.D., F.R.C.P. First edition, 1912. Williams & Wilkins Co. (exclusive U.S. agents), Baltimore 2, Maryland, 1960. 1111 pages. Price: $24.00.

INFECTIOUS DISEASES OF CHILDREN

By Saul Krugman, M.D., Professor and Chairman, Department of Pediatrics, New York University School of Medicine, New York, N.Y., and Robert Ward, M.D., Professor and Head, Department of Pediatrics, University of Southern California School of Medicine, Los Angeles, Calif. 2nd ed. C. V. Mosby Co., St. Louis, Mo., 1960. 398 pages. Price: $13.00.

RESUSCITATION OF THE NEWBORN INFANT; PRINCIPLES AND PRACTICE

Edited by Harold Abramson, M.D., Professor of Clinical Pediatrics, New York Medical College, New York, N.Y. C. V. Mosby Co., St. Louis, Mo., 1960, 274 pages. Price: $10.00.

COMPARATIVE EFFECTS OF RADIATION

Edited by Milton Burton, Chemistry Department and Radiation Laboratory, University of Notre Dame, Ind., J. S. Kirby–Smith, Biology Division, Oak Ridge National Laboratory, Tenn., and John L. Magee, Chemistry Department and Radiation Laboratory, University of Notre Dame, Ind. Report of a Conference held in San Juan at the University of Puerto Rico, February 1960, sponsored by National Academy of Sciences—National Research Council. John Wiley & Sons, Inc., 440 Park Avenue South, New York 16, N.Y., 1960. 426 pages. Price: $8.50.

THE QUESTION OF FERTILITY

By Georges Valensin, M.D., translated from the French by Leah Sucholdolski. (A discussion of fertility and fertilization for the general reader.) Doubleday & Co., Inc., Garden City, New York, N.Y., 1960. 296 pages. Price $4.50.

SYPHILIS

Modern Diagnosis and Management. U.S. Department of Health, Education, and Welfare, Public Health Service Publication No. 743, U.S. Government Printing Office, Washington, D.C., 1960. Sold by Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. 63 pages. Price: $2.00.

REGULATION OF THE INORGANIC ION CONTENT OF CELLS

Ciba Foundation Study Group No. 5. Ed. by G. E. W. Wolstenholme, M.A., M.B., M.R.C.P., and Cecilia M. O'Connor, B.Sc. Little, Brown & Co., Boston, Mass., 1960. 100 pages.

ADVENTURE TO MOTHERHOOD

The Picture-story of Pregnancy and Childbirth. By J. Allan Offen, M.D., Assistant Professor of Obstetrics and Gynecology, University of Miami School of Medicine, Fla. Audio Visual Education Co. of America, Inc., Miami, Fla., 1960. 70 pages. Price: $2.95.

COLLOQUIA ON ENDOCRINOLOGY, VOL. XIII

Human Pituitary Hormones. Ed. for Ciba Foundation by G. E. W. Wolstenholme, M.A., M.B., M.R.C.P., and Cecilia M. O'Connor, B.Sc. Little, Brown & Co., Boston, Mass., 1960. 336 pages. Price: $9.50.

CIBA FOUNDATION SYMPOSIUM ON CONGENITAL MALFORMATIONS

Edited by G. E. W. Wolstenholme, M.D., M.B., M.R.C.P., and Cecilia M. O'Connor, B.Sc. Little, Brown & Co., Boston, Mass., 1960. 308 pages. Price: $9.00.

BOOK REVIEWS

SURGERY OF THE FOOT

By Henri L. Du Vries, M.D., Clinical Instructor in Surgery, Chicago Medical School; Attending Surgeon, Columbus Hospital, Mother Cabrini Hospital, and Frank Cuneo Hospital; Chairman, Department of Surgery, Illinois College of Chiropody and Foot Surgery, Chicago. The C. V. Mosby Company, St. Louis, 1959, 494 pages. Price $12.50.

Near the turn of the century, one of the fathers of American orthopedics, Dr. Royal Whitman, pointed out that the study of normal and abnormal foot physiology was neglected in American medical schools. This is still true today. The modern student usually has a good background in unusual conditions such as lupus and carotid body tumors; however, he might have difficulty adequately treating a plantar wart or an overlapping toe. The practitioner will find the chapters on static foot deformities and on disorders of the toenails refreshingly practical. The book is not confined to strictly orthopedic disorders but includes infections, diabetic ulcers, tumors, skin disorders, neuropathies, and congenital defects. The photographs and illustrations are numerous and excellent. The text is well organized and surgical technique is presented in a short outline form. The book is, of course, concerned primarily with surgery of the foot with emphasis on the surgical rather than the conservative treatment. The text seems to slip over gout rather quickly, but in general this work would be a worthy addition to the library of those practitioners who treat foot conditions.—THOMAS O. MILLER, M.D.

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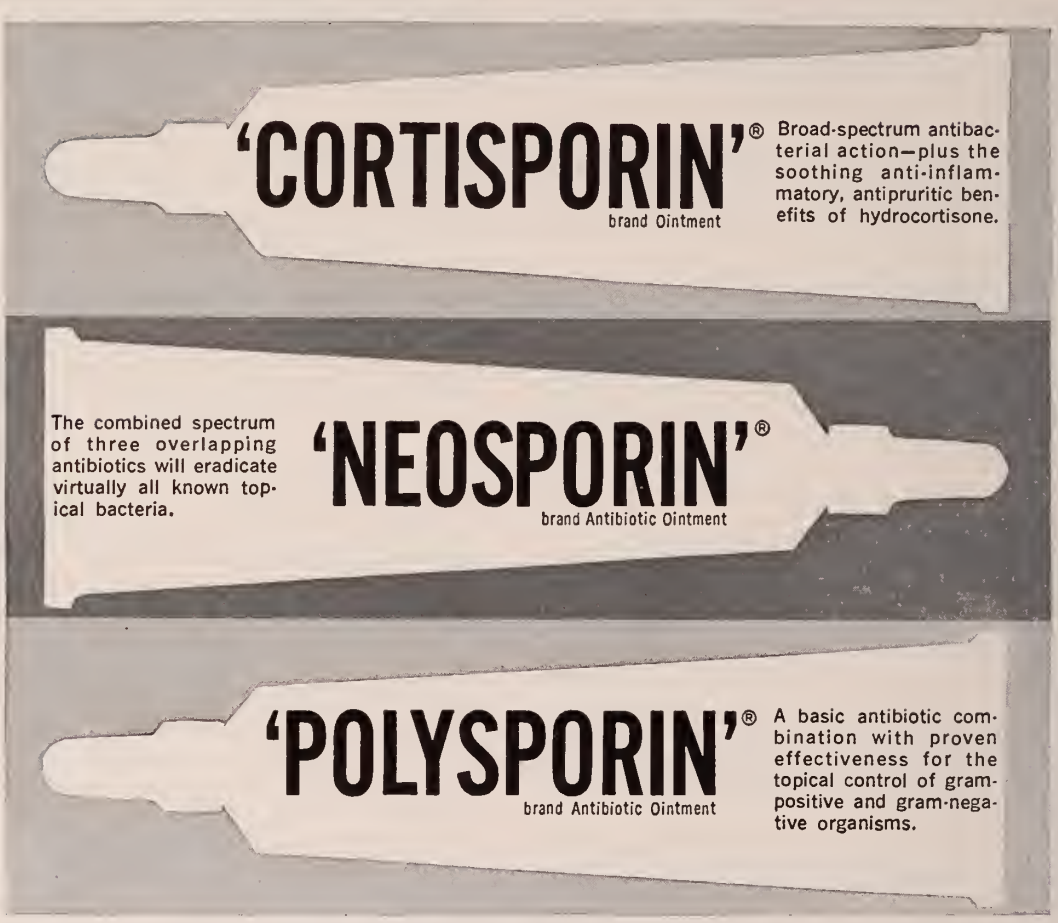

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the Wisconsin Medical Journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

VOL. 60, NO. 5—MAY 1961

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OPPOSED TO MEDICAL BILL

To the Superior Evening Telegram:

After listening to an interview of Secretary Abraham Ribicoff over the ABC network regarding Federal aid to education and medical assistance to the aged, I was overwhelmingly dismayed at the complete misinformation he covered regarding the American Medical Association.

As a member of the medical profession, I, as well as all physicians, have a sincere desire to help the aged. Secretary Ribicoff stated that the AMA opposes the administration health bill because it socializes doctors, when in reality it has nothing to do with doctors or socialism. This is a completely naive political statement.

We oppose the administration health legislation because it does not stand the test of feasibility. It does not cover the people who need it most. These are not the indigent for they are covered already through the old age assistance program. We want coverage for the people who are not indigent but who do not have the extra means to cover prolonged medical care. This type of assistance can and must be handled through the public welfare department, just as OAA is or money will be squandered. The Kerr–Mills bill passed in the last legislative session provided funds for this and must be implemented at all state levels.

To dispense money for medical care through the Social Security system is a wasteful and dangerous method. More often than not it will provide assistance when it is not needed, while those in need still remain in need. This has never been nor never will be the American way of doing things, I trust.

Duane L. Flogstad, M.D.
Shell Lake, Wisconsin

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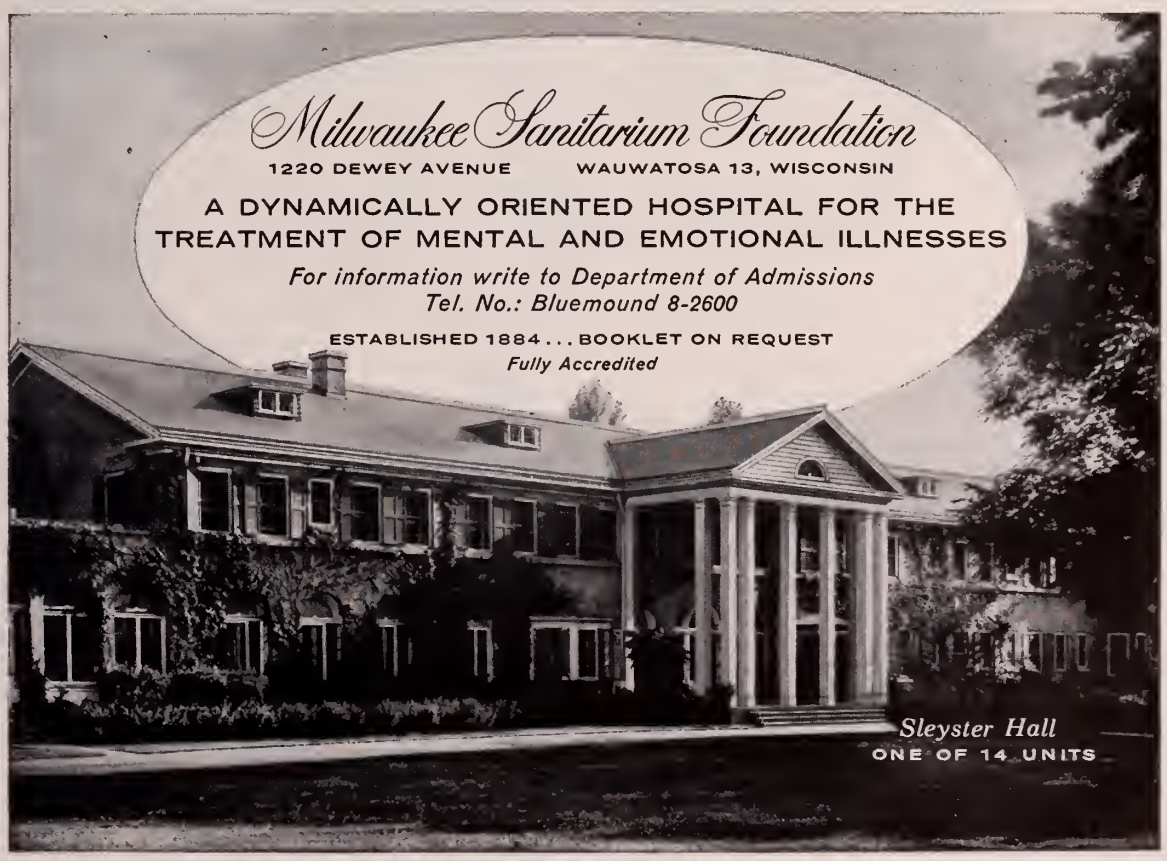

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BARRON-WASHBURN-SAWYER-BURNETT

Mr. Charles Johnson, AMA field representative from Chicago, addressed the Barron-Washburn-Sawyer-Burnett County Medical Society on "Health Legislation" at the February 7 meeting held in Rice Lake at the Land O'Lakes Hotel. Thirteen members were present. During the business session the group voted to activate the political committee.

At the March 14 meeting of the society, *Dr. R. C. Frank*, councilor of the tenth district, from Eau Claire, spoke to the group on State Medical Society activities with special attention given to activities regarding implementation of the Kerr-Mills law.

During the business session, $500 was granted to the county medical society auxiliary for the nurses and paramedical scholarship fund; $300 was granted to the student loan fund of the Charitable, Educational and Scientific Foundation of the State Medical Society; and a decision was made to extend an invitation to Congressman Lester Johnson to address the society at either the September or October meeting.

Pictured above as they attended the Brown County Medical Society meeting March 9 are, left to right: Drs. George Nadeau, A. J. McCarey, Frank Urban, R. M. Waldkirch, and H. J. Kief.

BROWN

Dr. A. J. McCarey was honored at the regular meeting of the Brown County Medical Society held March 9 at the Elks Club, Green Bay. As a token of the great appreciation in which Doctor McCarey is held by the State Medical Society and the Brown County Medical Society, for his many accomplishments and many honors, a chair was presented to him. This was the office chair used by him in Madison when he was president of the State Medical Society. The chair, as presented that night, bore an engraved brass plate.

Dr. H. J. Kief, sixth district councilor, Fond du Lac, was a guest and addressed the group. Doctor McCarey, chairman of the legislative and public health committee, also addressed the members urging passage of Bills 2, S. and 3, S. which concern the organization of public health departments. The Society voted to recommend passage of these bills.

Physicians whose names appear in italic are members of the Society.

COLUMBIA-MARQUETTE-ADAMS

New officers for 1961 of the Columbia-Marquette-Adams County Medical Society are as follows: president, *Dr. Ray R. Rueckert*, Portage, president-elect, *Dr. Fred W. Gissal*, Wisconsin Rapids; secretary-treasurer, *Dr. Robert T. Cooney*, Portage. Doctor Cooney was named delegate and Doctor Rueckert, alternate delegate, to the State Medical Society House of Delegates.

CHIPPEWA

Twenty-two members of the Chippewa County Medical Society heard Dr. Patrick Ongley, Mayo Clinic, Rochester, Minn., talk on "Treatment and Rehabilitation of Congenital Heart Disease in Children" at their March meeting. The meeting was held March 7 in Bloomer.

DANE

Members of the Dane County Medical Society heard reports on various matters at their April 11 meeting in Madison. *Dr. Charles W. Stoops*, president, reported from the Board of Trustees; *Dr. J. F. McIntosh*, chairman of the public relations committee, reported on a trip to the Kansas City Health Fair; *Dr. R. N. Allin*, chairman of the State Medical Society committee on Health Economics In American Life, reported on a recent trip to Washington, D. C.; and *Dr. P. B Golden*, chairman of the county society's delegates and alternates, reported on a recent meeting of that group.

The directors of the Dane County Medical Society Foundation for Medical Research announced that approximately $2,000 is available for support of medical research. The funds are available from the James and Clara Joss Foundation.

EAU CLAIRE

The Eau Claire County Medical Society, during March, presented a series of mid-day panel discussions on cancer. The series, presented in cooperation with television station WEAU-TV, is entitled "Quiz the Physician." Incoming telephone calls were screened and then answered by the physicians on the air.

FOND DU LAC

Members of the Fond du Lac County Medical Society heard *Dr. John L. Sims*, Madison, at their March meeting in Fond du Lac. Doctor Sims, professor in the department of medicine, University of Wisconsin Medical School, talked on "Problems in Gastrointestinal Bleeding." His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society and by Merck Sharp and Dohme.

KENOSHA

Special prizes for the Kenosha High Schools Science Fair, held March 19, were presented by the Kenosha County Medical Society. Student projects in biology, chemistry, general science, physics and mathematics were on display at the fair.

PIERCE–ST. CROIX

The Pierce–St. Croix County Medical Society met March 21 at the home of *Dr. Frederick Klaas*, Ellsworth.

POLK

Members of the Polk County Medical Society at their meeting March 16 heard *Dr. John Z. Bowers*, dean of the University of Wisconsin Medical School, Madison, talk on the growing need for an adequate supply of qualified candidates for medical school and the role of the medical school in postgraduate medical education. A question and answer session followed. Mrs. S. H. Ambrose, Whitewater, president of the Woman's Auxiliary to the State Medical Society, was also a guest speaker. The business session covered the need for providing adequate nursing care for the aged. The meeting was held at St. Croix Falls in the Dalles House.

Doctor Bowers' appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society.

SAUK

At the business session of the March 14 meeting of the Sauk County Medical Society a discussion was held on the programs launched by two drug manufacturers to reimburse state welfare departments 10% of the amount spent for prescriptions filled with their products for welfare clients. The subject was referred to the welfare committee for further study. A discussion on county immunization clinics, whether to allow out-of-county persons to participate, was referred to the liaison committee. No action was taken on a discussion involving responsibility of payment of telephone calls to the State Laboratory of Hygiene in reporting cultures.

The Sauk County Medical Society met for a dinner meeting and scientific program April 11 at the Warren Hotel in Baraboo. Dr. Nathan Smith of the University Hospitals, Madison, presented a talk on the Rh problem.

WALWORTH

Members of the Walworth County Medical Society heard *Dr. Robert F. Schilling*, Madison, talk on "Anemias" at the March 9 meeting at Delavan in the Village Inn. Doctor Schilling is an associate professor of medicine, University of Wisconsin Medical School. The CES Foundation of the State Medical Society sponsored his appearance.

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Milwaukee Academy of Medicine

Members of the Milwaukee Academy of Medicine met April 18 at the University Club for dinner and a scientific meeting. Dr. Albert H. Coons, Department of Bacteriology and Immunology, Harvard Medical School, was the guest lecturer. His subject was "Fluorescent Antibodies."

Milwaukee Neuro-Psychiatric Society

The Milwaukee Neuro-Psychiatric Society was host to the Wisconsin Psychiatric Association on Saturday, April 29, at Hotel Kaiser Knickerbocker, Milwaukee. Following dinner a business meeting of the Wisconsin Psychiatric Association was held.

The evening's scientific program was given by Dr. William Malamud, past president of the APA and now director of research of the National Association for Mental Health in New York City. His subject was "Dynamic Principles in Scientific Psychiatric Studies."

Milwaukee Academy of General Practice

Dr. Bertram Moss, Chicago, Ill., was the guest speaker at the spring membership meeting of the Milwaukee Academy of General Practice, Wednesday, April 5, at the Milwaukee Athletic Club. Doctor Moss is a family physician, a member of the American Academy of General Practice Committee on Mental Health, and national executive secretary of the Academy of Psychosomatic Medicine. Doctor Moss' talk was "Psychosomatic Medicine for the

---

Physicians whose names appear in italic are members of the Society.

Pictured above are, left to right: Dr. Norbert G. Bauch, president of the Milwaukee Academy of General Practice; Dr. John A. Kelble, program chairman of MAGP; and Dr. Bertram Moss, guest speaker for the April meeting of MAGP.

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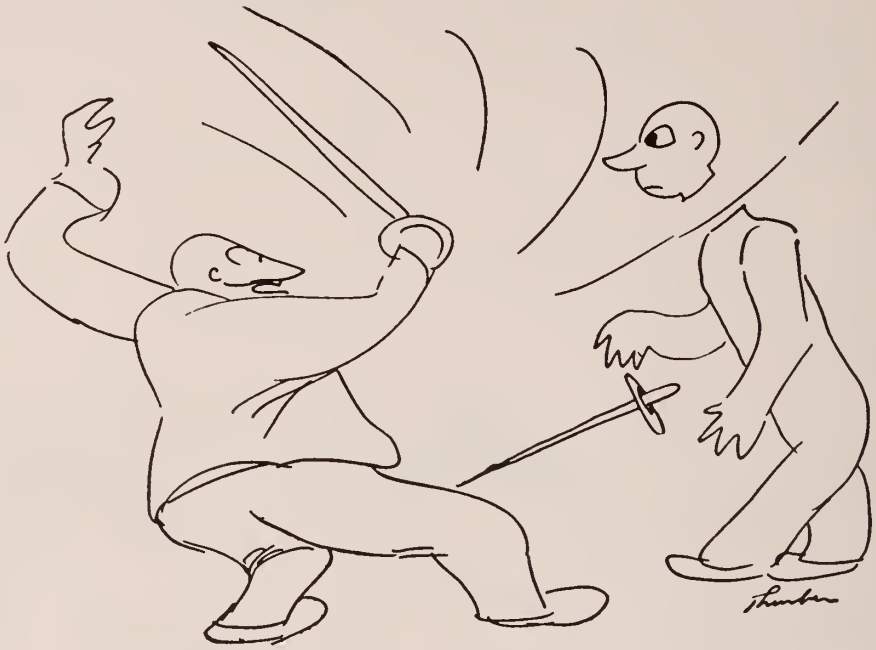

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NEWS OF WISCONSIN PHYSICIANS

Doctor Kalb Presents Allergy Papers

Dr. Clifford H. Kalb, Milwaukee, presented the following papers at The Second Bahamas Allergy Conference, held at the Emerald Beach Hotel, Nassau in the Bahamas, in February, 1961; Experiences with Emulsified Extracts in Allergic Problems" and "Bronchopulmonary Disturbances in Bronchial Asthma and Emphysema."

Dr. Windsor Speaks on Tetanus Immunization

Dr. Richard B. Windsor, Sheboygan, talked on tetanus immunization programs at the midwinter safety conference of the Wisconsin Safety Council in Milwaukee February 2–3.

Doctor Pomainville Busy Speaker

Dr. L. C. Pomainville, Wisconsin Rapids, president of the Wood County Cancer Society, gave a talk March 1 to the PTA at Rudolph on the subject, "Seven Danger Signals of Cancer." He also spoke to the PTA at Biron on April 18 on "Cancer and Quackery." He spoke to the Cancer Crusade Kickoff meeting at the Wisconsin Rapids YMCA building April 10 with "Cancer" as his topic. And he chose the same topic at the Marshfield Cancer Crusade Kickoff held April 12 at the Library building. On April 11 Doctor Pomainville addressed the Riverview Hospital nurses on "Colostomy Care." He addressed the Riverview Hospital staff April 14 on "Anomalous Kidneys." On April 17 he talked at a meeting of the South Wood County Medical Society on the life of Dr. William Beaumont.

Dr. Hansen Joins Janesville Radiologists

Dr. Thomas R. Hansen, who has just completed a residency in radiology at the Mayo Clinic, Rochester, Minnesota, joined *Drs. E. H. Betlach* and *M. J. Roesler* in the practice of radiology April 1. Doctors Betlach and Roesler are radiologists at Mercy Hospital, Janesville; Fort Atkinson Memorial Hospital, Fort Atkinson; and Memorial Community Hospital, Edgerton.

Doctor Hansen is a graduate of Wheaton College, Wheaton, Illinois, and the University of Illinois Medical School. He interned at Cook County Hospital, Chicago, Illinois, and was a flight surgeon in the United States Navy before beginning his residency in radiology at the Mayo Clinic.

Doctor James Attends Conference

Dr. Richard L. James, Valders, attended the Chicago Medical Society Clinical Conference in March.

Physicians whose names appear in italic are members of the Society.

Doctor Baertsch Serves Winter Community

Dr. L M. Baertsch of Hayward is now furnishing medical service for the community of Winter. In answer to a request from the Winter town board, the Hayward Clinic made arrangements for Doctor Baertsch to spend a half day a week in the community.

New Physician At Washburn

Dr. John G. Telford, De Kalb, Ill., has established a practice in Washburn. A graduate of Northwestern University Medical School, Doctor Telford served his internship and residency at Cook County Hospital in Chicago. He will also serve the Bayfield community.

Assistant Medical Editor of WMJ

Dr. Victor S. Falk, Jr., Edgerton, was appointed assistant medical editor of the WISCONSIN MEDICAL JOURNAL at a meeting of the Council in February. The newly created post will help to relieve the medical editor, *Dr. R. S. Baldwin*, Marshfield, of some of the many duties required. Doctor Falk has been a member of the Editorial Board since 1953.

V. S. Falk, M.D.

A graduate of the University of Wisconsin Medical School in 1939, Doctor Falk served his internship at Ancker Hospital, St. Paul, Minn. He received residency training in surgery at Carle Hospital Clinic, Urbana, Ill., and Augustana Hospital, Chicago, Ill. During the period 1941–1946 he served in the medical corps of the U. S. Navy.

Doctor Falk is a member of the Rock County Medical Society and the Wisconsin Surgical Society as well as the State Medical Society. He is surgeon for the Milwaukee Railroad, is chief of staff of Edgerton Memorial Community Hospital and is on the staff of Mercy Hospital, Janesville. He is also a fellow of the American College of Surgeons.

Doctor Larkin Moves To California

Dr. Charles B. Larkin, Madison, a specialist in internal medicine, left April 1 to accept a post at Patton State Hospital in San Bernardino, Calif. A 1949 graduate of the University of Wisconsin Medical School, he has been in private practice in Madison since 1950.

Doctor Erickson Leaves Plum City

Dr. Burt Erickson, who has practiced at Plum City since 1959, left the community in April to return to Colorado to establish a practice.

Facts about

WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON MEDICAL CARE PLANS

YEAR-END FINANCIAL REPORT

The following important facts are taken from the December 31, 1960, balance sheet of Wisconsin Physicians Service as audited by Donald E. Gill and Company, Madison, Certified Public Accountants:

Reserves—Total reserves in 1960 increased to $1,454,938.14. This is an increase in surplus (total reserves) of $263,426.61.

Premium Income—Premium income for 1960 totaled $9,144,159.83, an increase of more than $1,450,000 over 1959.

Surgical-Medical Benefits—83.22 per cent of surgical-medical earned income was paid in benefits compared with 87.40 per cent in 1959.

Hospital Benefits—The ratio of hospital benefits to earned income was 92.06 per cent compared with 119.46 per cent the previous year.

Administrative Expenses—Administrative expenses continued their downward trend to 12.08 per cent as compared with 13.24 per cent in 1959.

It is apparent that the great improvement in the ratio of hospital benefits to income over the past year is largely responsible for the marked improvement in the over-all financial results.

Since the inception of Wisconsin Physicians Service in 1946, WPS has paid benefits in the amount of $43,869,276.70.

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Doctor Price Attends Cairo Conference

Dr. James M. Price, professor of surgery at the Cancer Research Hospital, University of Wisconsin Medical School, left Madison in March to attend meetings of the International Union Against Cancer in Cairo, Egypt. Doctor Price presented a paper entitled "Studies on the Etiology of Bladder Cancer" at the conference.

Physicians Talk Before Medical Assistants

Dr. Robert M. Senty, Sheboygan, and *Dr. James S. Jensen*, Cedar Grove, were members of a panel which discussed medical ethics at the March meeting of the Washington-Ozaukee-Sheboygan County Medical Assistants Society.

Doctor Clatanoff Receives Lederle Award

Dr. Dallas V. Clatanoff, assistant professor of medicine at the University of Wisconsin Medical School, has been named recipient of the Lederle Medical Faculty Award. The third faculty member to receive a Lederle award, Doctor Clatanoff will receive $20,542.22 for a three-year period beginning July 1, 1961. His specialty is internal medicine. He has also taken training in hematology and has an active research program in the field of coagulation. A graduate of the University of Nebraska Medical School, he was an intern and resident at the University of Wisconsin Hospitals from 1951 to 1954 and a research fellow from 1954 to 1955 in the department of medicine. From 1955 to 1957 he was a Daland Research Fellow at the Thorndike Memorial Laboratory, Boston City Hospital. He returned to the university in 1957.

Doctor Kalb Presents Paper in Texas

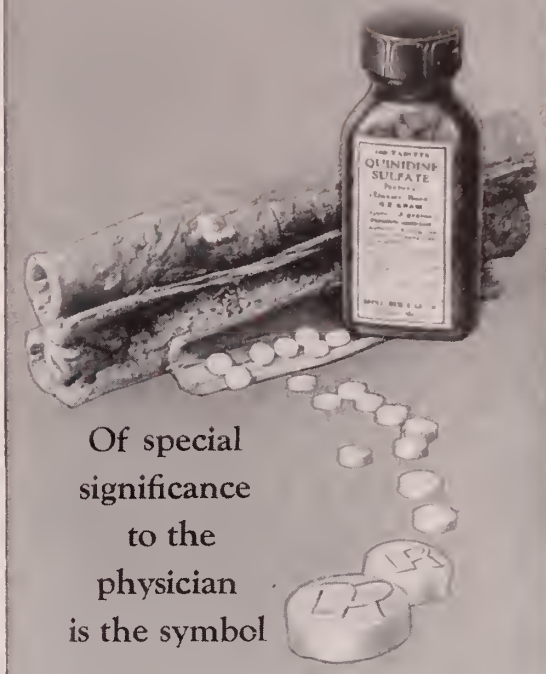
Dr. Clifford H. Kalb, Milwaukee, presented a paper on "Pulmonary Function Tests and Their Significance" for the American College of Allergists at its meeting in Dallas, Texas, in March.

Doctor Epperson Moves To Oconomowoc

Dr. Dean P. Epperson, Watertown, has moved his office to Oconomowoc. A consultant in surgery, he will occupy the former offices of *Dr. Greg Gallo* Doctor Gallo has terminated his general practice to serve at Oconomowoc Memorial Hospital as full-time anesthesiologist.

Doctor Borenz Director Of Guidance Center

Dr. Harold F. Borenz, Madison psychiatrist, will serve as director of the Rock County Child Guidance Center on a temporary basis. Doctor Borenz succeeds *Dr. Hertha Tarrasch*, Janesville. Doctor Borenz is director of the child psychiatric center at the University of Wisconsin Hospitals.



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In this day of complex and constantly changing economic and social conditions, even the so-called financial experts who devote a lot of study to the field of investments are frequently puzzled and mistaken about things in the investment field. I believe we will all agree that there are very, very few investments that one can afford to "BUY AND FORGET." Stocks that were good last year may not be doing good this year. Certainly, one of the very few investments that one can "BUY AND FORGET" is United States Savings Bonds. They are registered in the owners' names and may be replaced if lost, stolen or destroyed. Also, the principal and interest are guaranteed by the United States Government.

Savings Bonds now pay an attractive interest rate of 3 3/4 per cent, when held to maturity. In the case of Series E Bonds, you put in $75.00 and get back $100.00 at the end of 7 years and 9 months. The Treasury has a special H Bond if you need regular income which pays by Government check twice a year, yielding 3 3/4 per cent interest when held to maturity (10 years). These bonds are sold in minimum amounts of $500.

IF YOU ARE PLANNING FOR RETIREMENT and you need regular income, you may wish to consider exchanging your Series E Savings Bonds (and Fs and Js) into H Bonds. Furthermore, if you exchange the bonds in place of redeeming them, you delay your tax on the interest earned on the bonds offered in the exchange until you redeem the H Bond, or it matures, whichever comes earlier. In most cases the tax at that time is greatly reduced because of lower income, and the double exemption for those older than 65.

Certainly, a portion of every Doctor's investments should be in United States Savings Bonds. The freedom from speculation and worry is worth a great deal to a busy Doctor. You may buy these bonds through your bank automatically each month by instructing your banker to deduct from your account a designated amount you wish to invest. This requires almost no time on your part.

In behalf of the Wisconsin Savings Bonds Committee, we thank the Wisconsin Medical Journal for its cooperation in placing this important message before you!

Sincerely,

Harold F. Dickens

Harold F. Dickens
State Director for Wisconsin

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NEWS FROM THE MEDICAL SCHOOLS

MU Professor to International Symposium

Donald Greiff, Sc.D., professor in pathology at Marquette University School of Medicine, was one of 15 U.S. scientists named to participate in a symposium on radioactive hydrogen at Vienna, Austria, May 3–10.

The symposium was sponsored by the International Atomic Energy Agency and attracted 65 scientists from 14 countries to discuss the use and effects of Tritium in both the physical and biological sciences.

Mulholland Accepts Gundersen Professorship

John H. Mulholland, M.D., professor and chairman of the Department of Surgery at New York University College of Medicine, has accepted an invitation to become the third annual Adolf Gundersen Professor of Surgery at Marquette, May 15–17.

The New York surgeon will attend surgical conferences at Veterans Hospital, Wood, and Milwaukee County Hospital and will pay visits to the medical school, Children's Hospital and the new Animal Research Laboratories.

The Gundersen visiting professorship was established in 1958 in memory of the late Dr. Adolf Gundersen who established a clinic in La Crosse. The grant for special lectures was made by Drs. Alf H., Sigurd B. and Gunnar Gundersen, sons of the clinic founder.

Quarterly Grants and Gifts Report Given

Marquette University's medical school received a total of $179,560.00 for research and training and gifts for operating expenses for the December-to-March quarter just completed.

Research gifts from the U.S. Public Health Service and nine other health agencies totaled $103,895.00, with teaching and training gifts amounting to $73,315.00. Fellowship grants and operating gifts totaled $2,350.00.

Public Health Grants Awarded

Four research and three training grants totalling $173,011 have been awarded the Marquette medical school by the U.S. Public Health Service.

Research grants amounted to $113,487 with a $75,000 grant to Edwin H. Ellison, M.D., professor and chairman of surgery, ranking as the largest award. The amount was part of future support in a $450,000 five-year award made in March of 1960 for program support in surgical research.

Other grants made for research include: $19,440 to J. C. Peterson, M.D., professor and chairman of pediatrics for "Cardiopulmonary Research in Children;" $13,800 to Shirley A. Johnson, Ph.D., assistant professor in physiology, "Platelet Activity in Coagulation in Thrombocytopenia;" John B. Hitz, M.D., professor and chairman of ophthalmology and Arvid G. Holm, M.D., clinical instructor, for "Histologic Study of Regenerative Processes in the Eye."

Eugene S. Turrell, M.D., professor and chairman in psychiatry, has received an $18,000 grant for graduate training in psychiatry.

Marquette Medical School Appointments

Two major promotions and ten new faculty appointments have been announced by Dean John S. Hirschboeck of Marquette University School of Medicine.

Appointed assistant chairman of the Department of Physiology is Howard M. Klitgaard, Ph.D., associate professor in the department. Mark W. Garry, M.D., formerly associate professor of medicine and director of medical services at Veterans Hospital, Wood, has been made director of University Health Services. Doctor Garry will be in charge of all student health services and the outpatient unit of the medical school.

New appointments as assistant professors are: Konrad H. Soergel, M.D., in medicine; Desmond P. McNelis, M.D., James A. Johnston, M.D., and H. David Sackin, M.D., in psychiatry; Samuel R. McReadie, M.D., pathology.

Appointed as clinical instructors were: Roger L. Hepperla, M.D., and Sheldon Burchman, M.D., in anesthesiology; John E. Cordes, M.D., in medicine and Andrew Boyd, M.D., in obstetrics and gynecology.

Richard J. Haberle, Ph.D., has been appointed instructor in clinical psychology in the Department of Psychiatry.

Health Service Head Appointed

Mark W. Garry, M.D., formerly an Associate Professor of Medicine and Chief of Medical Services at Veterans Hospital, Wood, has been appointed Director of University Health Services at Marquette University.

Doctor Garry will serve on a full-time basis in his new post and will be in charge of all student health services and clinical activities of the outpatient unit of the medical school.

A 1934 graduate of the Marquette Medical School, Doctor Garry served on the faculty at Marquette from 1948 through last summer when he resigned to accept a post at the Veterans Hospital, Des Moines, Iowa.

Speaker at Medical Alumni Meeting

A pioneer in the field of preventive surgery, Dr. Jonathan E. Rhoads, John Rhea Barton Professor of Surgery, University of Pennsylvania Medical School, was a guest speaker at the annual Alumni Day Program of the Wisconsin Medical Alumni Association, Inc., May 19, in Madison.

Doctor Rhoads spoke on the subject "Dynamic Boundaries of Preventive Surgery," a review of recent advances in the prevention of disease by surgical means and the balancing of risks against anticipated gains.

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MEDICAL MEETINGS—POSTGRADUATE COURSES

A.M.A. Chicago Meeting in 1962

The Council on Scientific Assembly invites physicians to submit titles and brief abstracts of scientific papers they wish to deliver at the 1962 annual meeting of the American Medical Association, which will be held in Chicago, June 11–15. The deadline is October 15.

"We would like to receive as many titles and abstracts as possible," said Council Chairman Samuel P. Newman, of Denver, "because in that way we have better selection and this, in turn, assures a more timely and better scientific program."

Dr. Newman urged physicians to contact members of the council in their own regions and discuss prospective papers with them.

The A.M.A. meeting in '62 will be held in Chicago's new $35,000,000 exposition center on Lake Michigan, which has 300,000 square feet of exhibit space alone.

Physicians who wish to participate in the Chicago scientific program and desire information are invited to write to Dr. Charles Bramlitt, Secretary, Council on Scientific Assembly, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois, or to any council member.

American Psychiatric Association

Scientific papers are now being accepted for consideration by the Program Committee for the 1961 Midwest Divisional Meeting of the American Psychiatric Association, Nov. 16, 17 and 18. The Program Committee is also interested in those wanting to participate in the program as panelists.

More than 800 physicians and guests are expected to attend the meeting, according to Charles W. Landis, M.D., Director of Mental Health for Milwaukee County Institutions and Departments, and general chairman of the meeting. All physicians and paramedical personnel are invited.

Abstracts of papers (400 words) should be submitted to the Milwaukee Divisional Meeting Executive Office, 756 North Milwaukee Street, Milwaukee, Wisconsin, % B. Cullen Burris, M.D., Program Chairman, *no later than June 1.*

Chest Physicians Postgraduate Courses

The Council on Postgraduate Medical Education of the American College of Chest Physicians will present the following postgraduate courses during 1961:

Cardiopulmonary Problems in Children
Brown Hotel, Denver, Colorado, July 24–28

Industrial Chest Diseases
Warwick Hotel, Philadelphia, September 25–29

Clinical Cardiopulmonary Physiology
Sheraton-Chicago Hotel, Chicago, October 23–27

Recent Advances in the Diagnosis and Treatment of Heart and Lung Diseases
Park Sheraton Hotel, New York City, November 13–17

Recent Advances in Diseases of the Chest
Statler-Hilton Hotel, Los Angeles, December 4–8

Tuition for each course is $75 for members of the American College of Chest Physicians and $100 for nonmembers. The fee includes attendance at the round table luncheon discussions.

Further information may be obtained by writing the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11.

World Medical Association

The fifteenth general assembly of The World Medical Association will be held September 15–20 at Rio de Janeiro, Brazil.

A special chartered plane, leaving Paris on September 9 arriving in Rio de Janeiro on September 10 has tentatively been scheduled to provide first class accommodations at economy prices for the doctors and their families who will attend the General Assembly of The World Medical Association.

A special program of general sightseeing with experienced bilingual guides will be available from September 11th to 14th to those joining the chartered tour. Following the adjournment of the General Assembly the tour will visit Brasilia on September 21; Sao Paulo September 22 and depart for Paris on September 24, arriving on September 25, 1961.

The approximate cost for each participant will be $966.00. This price will include all air transportation, first class hotel; accommodations; the registration fee; general sightseeing with tour conductors and guides and three meals daily while on the visit to Sao Paulo and Brasilia.

To obtain additional information address inquiry to: The World Medical Association, 10 Columbus Circle, New York 19, New York.

Rocky Mountain Cancer Conference

The 15th Annual Rocky Mountain Cancer Conference will be held at Denver's completely air-conditioned Brown Palace West, July 12, 13, and will feature panel discussions on "Detect Cancer in Time!—Procedures, Problems and Solutions," and "Neoplasms of the Female Genital Tract."

Presidents of both the American Cancer Society and the American Medical Association will participate in the two day program. Application has been made for A.A.G.P. accreditation for the Conference.

The Rocky Mountain Cancer Conference, held annually in Denver, is co-sponsored by the Colorado

WISCONSIN CALENDAR COMING EVENTS

1961

May 24: Maternal Mortality Institute, St. Mary's Hospital, Wausau.

June 10: Annual Meeting, Wisconsin Heart Association, Milwaukee.

June 21: Conference on Medical Aspects of Mental Retardation, Brooks Auditorium, Milwaukee.

June 26–30: AMA Annual Meeting, New York, New York.

July 28–29: SMS Council meeting, Land O' Lakes.

Aug. 29–31: UW Postgraduate course, Psychiatric symposium, Dr. R. Roessler, chrm., Wisconsin Center Building, Madison.

Sept. 28–30: UW postgraduate course, Anesthesiology, Dr. O. S. Orth, chrm., University Hospitals, Madison.

Oct. 13–14: UW postgraduate course, Psychiatry, Dr. R. Roessler, chrm., Wisconsin Center Building, Madison.

Nov. 16–18: UW postgraduate course, Rehabilitation of Patients with Injuries of the Spinal Cord, Dr. A. Siebens, chrm., Wisconsin Center Building, Madison.

Nov. 28–Dec. 1: AMA Clinical Meeting, Denver, Colorado.

1962

Apr. 5–7: UW postgraduate course, Genetics in Pediatrics, Drs. J. Crow and N. Smith, co-chrm., Wisconsin Center Building, Madison.

Apr. 26–28: UW postgraduate course, Psychosomatic Medicine, Dr. David Graham, chrm., Wisconsin Center Building, Madison.

May 10–11: UW postgraduate course, Orthopedic Surgery, Dr. H. Wirka, chrm., Wisconsin Center Building, Madison.

May 17–19: UW postgraduate course, Anatomy, Physiology and Pathology of the Holocrine, Apocrine and Eccrine Glands, Dr. S. Johnson, chrm., Wisconsin Center Building, Madison.

June 11–15: AMA Annual Meeting, Chicago, Illinois.

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California.

MEDICAL MEETINGS *continued*

Division of the American Cancer Society and the Colorado State Medical Society.

Further information may be obtained by writing Rocky Mountain Cancer Conference, 835 Republic Bldg., Denver 2, Colorado.

Intensified Course in the Use of Emulsified Extract

Under the auspices of The American College of Allergists, an intensive two-day course concerned with the use of emulsified extracts in the treatment of respiratory tract allergy will be conducted on Saturday and Sunday, May 27–28, at the Pick–Congress Hotel, Chicago, Illinois, by a small group of physicians headed by Dr. Ethan Allan Brown of Boston. This course will deal with the technical and clinical aspects and applications of this important advance in the method of treatment. Lawrence J. Halpin, M.D., Cedar Rapids, Iowa, will act as Chairman and Moderator, with Morris A. Kaplan, M.D., of Chicago, and Clifford H. Kalb, M.D., of Milwaukee, as Co-Chairmen.

Address all communications regarding reservations and any inquiries regarding arrangements to: Eloi Bauers, Executive Vice President, The American College of Allergists, 2160 Rand Tower, Minneapolis 2, Minnesota. Telephone: FEderal 2–2948.

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Intensive Postgraduate Courses

STARTING DATES—SPRING–SUMMER, 1961

General Surgery, One Week, May 8
Surgical Technic, Two Weeks, June 5
Surgery of Colon & Rectum, One Week, June 5
Gallbladder Surgery, Three Days, June 19
Surgery of Hernia, Three Days, June 22
Advanced Electrocardiography, One Week, June 19
Gynecology, Office & Operative, Two Weeks, June 12
Vaginal Approach to Pelvic Surgery, One Week, May 15
Practical Cystoscopy, Ten Days, by appointment
General Practice Review, One Week, May 22
Neuromuscular Diseases of Children, Two Weeks, June 12
Fractures & Traumatic Surgery, Two Weeks, June 12
Thoracic Surgery, One Week, June 19
Blood Vessel Surgery, One Week, May 15
Breast & Thyroid Surgery, One Week, May 22
Hematology, One Week, June 12

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A MEDICAL CONFERENCE ON

Medical Aspects of Mental Retardation

MARQUETTE UNIVERSITY • BROOKS MEMORIAL AUDITORIUM • 620 NO. 14th ST

Milwaukee • Wednesday • June 21

NO FEE: This program is made possible without registration fee, through a grant of the Wisconsin Council for the Mentally Retarded Children, to the Charitable, Educational and Scientific Foundation of the State Medical Society, and support from the Mental Hygiene Division of the Wisconsin Department of Public Welfare.

CONFERENCE CHAIRMAN: H. Kent Tenney, M. D., Madison

A. M.

9:30—REGISTRATION (2nd Floor of Brooks Memorial Union, 2nd Floor Outside of Ballroom)

10:00—WHAT THIS CONFERENCE IS DESIGNED TO ACCOMPLISH: Dr. H. Kent Tenney

10:15—MEDICAL AND NONMEDICAL EVALUATION OF THE GROWING CHILD:

1. **WHAT CAN BE EXPECTED OF THE PHYSICIAN: Reynold A. Jensen, M. D.,** Professor of Psychiatry and Pediatrics, University of Minnesota Medical School, Minneapolis
2. **EDUCATIONAL EVALUATIONS OF MENTAL CAPACITY AND POTENTIAL GROWTH: Eldon Bond, Ph. D.,** Assistant Superintendent of Schools, Milwaukee

11:15—COUNSELING AND PLANNING WITH THE FAMILY:

1. **CLASSIFICATION OF MENTAL LEVELS AND INTERPRETATION TO THE FAMILY: A. A. Lorenz, M. D.,** Eau Claire
2. **EXISTING RESOURCES, AND WHO SHOULD USE WHAT: Leonard J. Ganser, M. D.,** Director, Mental Hygiene Division, Department of Public Welfare, Madison
3. **WHAT THE PARENT EXPECTS OF THE PHYSICIAN: Mr. G. I. Wallace,** Madison

P. M.

12:30—EDUCATIONAL CLASSIFICATION AND EVALUATION OF THE MENTALLY RETARDED CHILD: James McCarthy, Ph. D., Institute for Exceptional Children, Urbana, Ill. **(Tentative)**

1:00—SUMMARY OF CONFERENCE TO THIS POINT: Doctor Jensen (10 minutes)

1:15—LUNCH: A special luncheon is provided at the Cafeteria of Brooks Memorial Auditorium, at $2.00. Tickets will be available at the Registration Desk.

Moderator: E. D. Schwade, M.D., Milwaukee, Chairman of Division on Nervous and Mental Diseases of Commission on State Departments, State Medical Society

2:00—CASE PRESENTATIONS AND DISCUSSION

1. Cases Suitable for Home Care (with Parent Participation)
2. Institutionalized Care (Patients from Southern Colony) Presented by **Henry Veit, M. D.,** Milwaukee, Consultant, Southern Colony, Union Grove

3:40—COFFEE BREAK

4:00—WHAT RESEARCH IS DOING IN THE AREA OF MENTAL RETARDATION.

1. **BIOCHEMICAL RESEARCH AND ITS SIGNIFICANCE TO THE PRACTICING PHYSICIAN: Harry Waisman, M. D.,** Professor of Pediatrics, University of Wisconsin Medical School
2. **GENETIC RESEARCH AND ITS APPLICATION TO MENTAL RETARDATION: David Smith, M. D.,** Associate Professor of Pediatrics, University of Wisconsin Medical School, Madison
3. **EDUCATIONAL RESEARCH: Robert Erdman, Ed. D.,** Associate Professor of Education and Chairman, Department of Exceptional Children, University of Wisconsin—Milwaukee

5:00—WHAT WE HOPE WE HAVE ACCOMPLISHED: Doctors Tenney and Jensen

5:30—ADJOURNMENT

Co-sponsors, with the Charitable, Educational and Scientific Foundation, State Medical Society: Division on Nervous and Mental Diseases, the Wisconsin Council for Mentally Retarded Children, the Wisconsin Association for Mental Health, the Wisconsin Academy of General Practice, the Mental Hygiene Division, Department of Public Welfare, the Bureau of Handicapped Children, Dept. of Public Instruction, The Wisconsin State Board of Health, Marquette University School of Medicine and the University of Wisconsin Medical School.

You are invited...

SPECIAL ONE-DAY JOINT MEETING OF THE AMA SECTION ON DISEASES OF THE CHEST AND THE AMERICAN COLLEGE OF CHEST PHYSICIANS

For the first time during an AMA Annual Meeting, one full day—Monday, June 26—will be devoted to bringing you up-to-date on all new advances in the fast-changing cardiopulmonary field. On hand will be top researchers and practitioners to discuss the most recent clinical findings in the treatment of chest diseases, and several sessions will be open to questions and answers. Take advantage of this unprecedented opportunity—plan now to attend.

Program Synopsis—Monday, June 26 only

Presiding: Dr. Herman Moersch, Rochester, Minnesota
Director of Medical Education and Research of the American College of Chest Physicians and Chairman of the AMA Section on Diseases of the Chest

Symposium: NEW APPROACHES TO ACQUIRED HEART DISEASE—Dr. Arthur M. Master, New York, Moderator. Coliseum, 9:15 a.m.

Panel: STEROID TREATMENT IN PULMONARY DISEASE
Dr. Sol Katz, Washington, D. C., Moderator
Coliseum, 10:45 a.m.

Luncheons: SIX SEPARATE LUNCHEONS—SIX SEPARATE TOPICS. Park-Sheraton Hotel. Reservations necessary.

Symposium: MODERN DIAGNOSTIC MEASURES IN CARDIAC DISEASE—Dr. George C. Griffith, Los Angeles, Moderator
Coliseum, 2:15 p.m.

Conferences: 36 tables, each headed by a prominent chest physician, discussing recent advances in treatment of cardiopulmonary diseases. Commodore Hotel, 8:15 p.m.

See Convention Number, J.A.M.A., April 29, for complete scientific program, advance reservation, hotel housing applications and luncheon reservation form.

AMA 110th Annual Meeting · New York · June 25-30

BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

NEW BOOKS RECEIVED

HELP–BRINGERS

Versatile Physicians of New Jersey. By Fred B. Rogers, M.D., Professor of Preventive Medicine, Temple University School of Medicine, Philadelphia, Penn. Vantage Press Inc., 120 W. 31st Street, New York 1, N.Y., 1960. 125 pages. Price: $2.95.

EPIDEMIC

Frank G. Slaughter. Doubleday & Company, Inc., New York. 1961. 286 pages. Price: $3.95.

PIONEER MICROBIOLOGISTS OF AMERICA

Paul F. Clark, M.D., Emeritus Professor, Medical Microbiology, University of Wisconsin. University of Wisconsin Press, Madison. 1961. 369 pages. Price: $6.00.

EVALUATION OF DRUG THERAPY

Proceedings of Symposium on evaluation of drug therapy in neurologic and sensory diseases, University of Wisconsin, May 1960. Ed. Francis M. Forster, M.D., Professor and Chairman, Department of Neurology, University of Wisconsin. University of Wisconsin Press, Madison. 1961. 167 pages. Price: $4.00.

KEY AND CONWELL'S MANAGEMENT OF FRACTURES, DISLOCATIONS, AND SPRAINS

Seventh Ed. H. Earle Conwell, M.D., F.A.C.S., Associate Professor, Orthopedic Surgery, University of Alabama School of Medicine, and Fred C. Reynolds, M.D., Professor, Orthopedic Surgery, Washington University School of Medicine, Mo. C. V. Mosby Co., St. Louis, Missouri. 1961. 1153 pages. Price: $27.00

ATLAS OF OBSTETRIC TECHNIC

J. Robert Willson, M.D., M.S., Professor, Obstetrics and Gynecology, Temple University School of Medicine, Philadelphia, Pa. C. V. Mosby Company, St. Louis, Mo. 1961. 304 pages. Price: $14.50, deluxe edition; $12:50, regular edition.

THE HUMAN FRAME

Giovanna Lawford. Anchor Books, Doubleday & Company, New York. 1961. (First published 1952) 109 pages. Price: 95¢.

PSYCHOTHERAPY AND SOCIETY

Wladimir G. Eliasberg, M.D., Ph.D., F.A.P.A. Philosophical Library, Inc., New York. 1959. 223 pages. Price: $6.00.

STROKE; A STUDY OF RECOVERY

Douglas Ritchie. Doubleday & Company, New York. 1961. 192 pages. Price: $3.50.

THE LIST METHOD OF PSYCHOTHERAPY

Elizabeth Sher, et. al., with an introduction by Jacob S. List. Philosophical Library, Inc., New York. 1960. 259 pages. Price: $7.50.

HAEMOPOIESIS; CELL PRODUCTION AND ITS REGULATION

Edited for the Ciba Foundation by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A. Little, Brown & Company, Boston, Mass. 490 pages. Price: $11.00.

NEW AND NONOFFICIAL DRUGS

As Evaluated by the Council on Drugs of the American Medical Association, 1961. J. B. Lippincott Company, Philadelphia, Pa. 1961. 849 pages.

THE MANAGEMENT OF THE DOCTOR-PATIENT RELATIONSHIP

Richard H. Blum, Ph.D., formerly Director of Research, Medical Review and Advisory Board,, California Medical Association. McGraw–Hill Book Company, Inc., New York. 1960. 304 pages. Price: $8.50.

A SYNOPSIS OF CONTEMPORARY PSYCHIATRY

G. A. Ulett, M.D., Ph.D., Professor, Department of Psychiatry and Neurology, Washington University School of Medicine, St. Louis, Mo. and D. Wells Goodrich, M.D., Chief, Biosocial Growth Center, National Institute of Mental Health. 2nd Ed. C. V. Mosby Company, St. Louis, Mo. 1960. 309 pages. Price: $6.50.

BOOK REVIEWS

SYNOPSIS OF EAR, NOSE, AND THROAT DISEASES

By Robert E. Ryan, B.S., M.D., M.S. (A.L.R.) F.A.C.S., Department of Otolaryngology, St. Louis University School of Medicine, William C. Thornell, A.B., B.M., M.D., M.S. (ALR), F.A.C.S., Assistant Professor Department of Otolaryngology, Cincinnati, College of Medicine, University of Cincinnati, Hans von Leden, M.D., F.A.C.S., F.I.C.S., Assistant Professor of Otolaryngology, Northwestern University Medical School, Chicago. The C. V. Mosby Company, St. Louis, 1959. 383 pages. Price: $6.75.

It is a concise ear, nose and throat handbook. It may well serve the family physician, intern and resident as a prompt manual guide for daily outpatient or emergency practice. The general emphasis is on clinical practice, especially treatment. If this book had described more about the practical approach to the diagnostic point, including simple interpretation of the common necessary x-rays and pictorial exhibition of visual examination for the diseases, I would be much more impressed. I feel also that the applied physiology of nose and internal ear, and the explanation of respiratory tract allergy is somewhat vague and inadequate.

However, generally speaking, it is one of the recommendable books to have at hand.—CHIN MOOK CHUNG, M.D.

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BOOKSHELF *continued*

A BIBLIOGRAPHY OF INTERNAL MEDICINE; SELECTED DISEASES

By Arthur L. Bloomfield, M.D., Professor of Medicine, Emeritus, Stanford University School of Medicine. The University of Chicago Press. 1960. 312 pages. Price: $6.00.

Understanding of a concept demands a knowledge of the evidence upon which it is based and the context in which it developed. This is as true in medicine as in philosophy, sociology, or any other discipline. Despite this and the fascinating content of the subject itself, interest in medical history has been difficult to arouse in all but the most unusual students or the senior scholars who have reached a period where contemplation has replaced action—a deficit which many medical educators have long deplored. Acting on the belief that all true education must involve active participation by the student, Doctor Bloomfield has developed a guide book to the vast mass of medical literature relating to a number of well known diseases—myocardial infarction, bacterial endocarditis, leukemia, Graves' disease and gout, to name a few. Publications of fundamental importance in the development of knowledge in these areas from the beginning of the 19th century almost to the present date are listed. For each there is a critical commentary which indicates both its general content and its place in the total pattern. To pursue this bibliography is to pursue the history of ideas and concepts more than of men and events, but certainly it is these ideas that are important, and interest in the men who devoloped them and the environment in which they worked cannot but follow. The arrangement of the book is such that by skimming of titles and commentary, one can easily select a portion of the references in a given field for pursuit of an individual problem if systematic reading is not practical. This bibliography will be a useful and stimulating addition to the library of any physician who is truly interested in medicine as an art and science rather than a technique.—J. LeRoy Sims, M.D.

CHRONIC ILLNESS IN A RURAL AREA

Chronic Illness in the United States, volume III. The Hunterdon Study. Reported by Ray E. Trussell, M.D., M.P.H., Jack Elinson, Ph.D. The Commonwealth Fund, Harvard University Press, Cambridge, Massachusetts. 1959. 440 pages.

As the title indicates this is a study of chronic illness in a rural area and it represents Volume 3 in a series of study surveys titled "Chronic Illness in the United States."

The locale of the endeavor takes place in Hunterdon County in northern New Jersey. This county covers approximately 435 square miles and, as of 1950 census, has a population of 42,700 people. It is made up of farms, woodlands, rural townships, and a few small industries. There are 26 municipalities which are responsible for meeting their own health and educational needs. (There are quite a few counties, therefore, in our own state of Wisconsin which

are similar in the above respects to the one studied.)

The survey is divided into 5 parts:

Part 1—Dealing with the Background Organization
Part 2—The Mechanics of the Family Interview
Part 3—Clinical Evaluations
Part 4—Test Procedures (multiple screening, etc.)
Part 5—Methodology.

It is, of course, inevitable that in a survey of this kind that clinical statistics and accounting data comprise a large segment of the contents. An interesting and important point was noted, that in this particular survey it was possible to institute more intensive methods in setting up working procedures preliminary to the actual survey than those used in prior surveys such as, "Chronic Illness in a Large City—In the Nation, etc." This was due, no doubt, to the provincialism of the locality.

The astonishing success achieved by the survey teams in enlisting the cooperation of volunteer workers from school children on through to all social and civic groups, including church, radio, and TV media, proved conclusively that the success of the survey in final analysis depended upon the voluntary participation of the public. Without this amazing cooperation the results would have had only limited value.

As expected there was the realization that it was going to be difficult to correctly distinguish between disease and illness—Dr. G. Rosen spells out this distinction in his treatise "Specialization of Medicine" by stating that "disease is an abnormal structure or functioning; illness is the feeling of discomfort usually arising out of disease." Recognizing the above, the reader will find numerous references and memoranda to what is called "manifest and nonmanifest" diseases.

Not discounting in the least the final results of the survey clinically and otherwise, the reviewer was particularly impressed by the procedures used in conducting the survey, especially those of the following: (1) the use of volunteer workers in establishing a work base; (2) the composition of each evaluating team, consisting of a physician, a medical social worker, and a public health nurse, to correctly correlate their respective spheres of evaluations; and (3) the composition and analysis of the Family Interview Questionnaire which was uniquely designed to elicit information on the total amount of chronic illness and disability within the community —and the astonishing success achieved in establishing its goal.—FRANK KEENA, Director of Public Welfare, Ashland County, on behalf of William J. Smiles, M.D.

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WANTED: MEDICAL DIRECTOR for institution for the retarded. General practice and administrative experience required. Salary $14,160 to $21,060 depending on qualifications. Write: Mr. A. C. Nelson, Superintendent, Northern Colony and Training School, Chippewa Falls, Wisconsin. g11tf

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EXCELLENT OPPORTUNITY: Retiring physician in suburban Sheboygan offers office and completely furnished house. Will sell on a land contract. Gottsacker Real Estate Company, Security National Bank Bldg., Sheboygan, Wisconsin. p4–6

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WANTED: Young general practitioner interested in obstetrics and pediatrics to join small group in central Wisconsin city of 20,000. Salary, leading to partnership. Contact Dept. 914 in care of the Journal. m5–6

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LOCUM TENENS AVAILABLE for two weeks between May 20 and June 20. Would fill in for general practice with a surgical and obstetrical orientation or a general surgical practice. Contact Dept. 915 in care of the Journal. m–5

OPENINGS AVAILABLE: 25-men group practice desires 2 ophthalmologists, 1 psychiatrist, 1 orthopedist, 1 allergist, 1 proctologist, and 3 general practitioners. Inquire of R. G. Zach, M.D., The Monroe Clinic, Monroe, Wisconsin. 2tf

the Wisconsin Medical Journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

VOL. 60, NO. 6—JUNE 1961

STATE MEDICAL SOCIETY OF WISCONSIN
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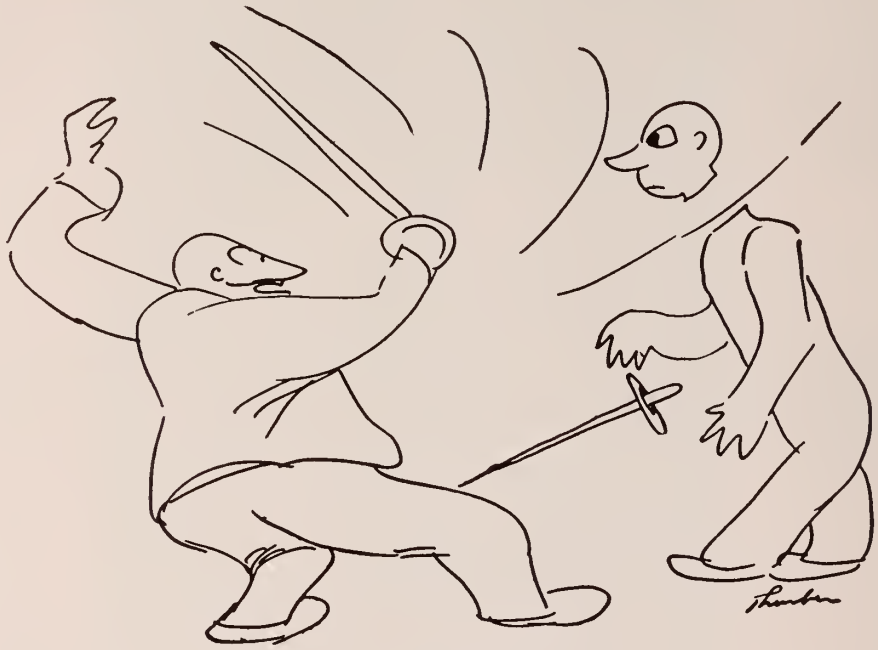
FOUNDATION PROGRESS

NEW CONTRIBUTIONS

The Woman's Auxiliary to the State Medical Society of Wisconsin has continued its enthusiastic and devoted interest in the Foundation with a new contribution.

During the recent Annual Meeting of the State Medical Society, the Auxiliary presented a check in the amount of $500 to the Foundation officers. The contribution is to be earmarked for the Student Loan Program.

In recognition of its interest and important role in Foundation affairs, the Auxiliary has been asked to name a continuing CES Foundation Committee within its own structure to guide activities in support of the many projects of the Foundation among its members.



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DODGE

The Beaver Dam Medical Forum met on Monday, March 20. The speaker of the evening was *Dr. D. L. Link.* His subject was "Diabetic Acidosis." Doctor Link reviewed the literature up-to-date on this important subject and stressed the importance of treating the potassium deficiency most always present in this disorder. He pointed out the danger of over treating with solutions containing sodium and chloride. He also stressed the simple method of checking the degree of acidosis by checking for acetone in cereal dilutions of plasma. He also reviewed methods of treating the diabetic in severe acidosis with insulin therapy.

On April 17 *Dr. J. A. Szweda,* internist, spoke to the Beaver Dam Medical Forum on the subject, "Common Forms of Congenital Heart Disease." He briefly reviewed the types of congenital heart disease seen in general practice and placed particular stress on the physiologic alterations produced by these cardiac abnormalities. He then reviewed the common physical signs specific to each condition. Using lantern slides he illustrated the laboratory techniques utilized in arriving at a specific diagnosis. These included demonstrations of cardiac catheterization techniques.

Physicians whose names appear in italic are members of the State Medical Society.

PIERCE-ST. CROIX

A joint meeting of the Pierce-St. Croix County Medical Society and the druggists was held April 18 at Hotel Dibbo-Hudson in River Falls.

SAUK

Dr. E. S. Gordon of the University of Wisconsin Medical Center, Madison, was guest speaker at the May 9 meeting of the Sauk County Medical Society. The dinner meeting was held at the Sauk County Hospital and Home in Reedsburg. Subject of Doctor Gordon's talk was "Diabetes."

WASHINGTON

The Washington County Medical Society met March 23 at Slinger in the Linden Inn. *Dr. Jack D. Spankus,* Milwaukee, spoke on "Fractures of the Upper Extremity." During the business session, a motion was passed to send subscriptions of AMA NEWS to newspapers, radio stations and labor unions located in the county.
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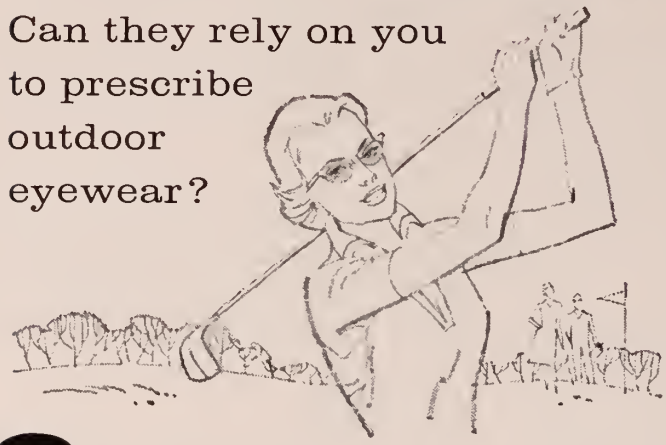

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Milwaukee Oto-Ophthalmic Society

The April 25 meeting of the Milwaukee Oto-Ophthalmic Society featured Dr. Irving H. Leopold, professor of ophthalmology at the University of Pennsylvania, who spoke on "Recent Advances in Ocular Therapy."

Wisconsin Chapter, American College of Chest Physicians

The Wisconsin Chapter of the American College of Chest Physicians held its annual meeting on May 2. The subject of scientific presentation was bronchial asthma and emphysema.

The following were elected to office for the 1961–1962 year: president—*Dr. Raymond R. Watson*, vice-president—*Dr. John Huston*, and secretary-treasurer—*Dr. Lloyd K. Mark*, all of Milwaukee.

Wisconsin Urological Society

The Wisconsin Urological Society held its 34th annual meeting at the Milwaukee Inn on April 15. Dr. Wyland F. Leadbetter, chief of urology, Massachusetts General Hospital, Boston, was the guest speaker. On April 14, he presented a paper on "Urinary Calculi" at the Veterans Administration Hospital, Wood, during Grand Rounds. In the afternoon he presented a movie on "Cystectomy with Ileal Loop Diversion" at the Milwaukee County General Hospital. On April 15, he presented a paper on "Testes Tumors" and also one on "Urinary Diversion."

Additional guest speakers included *Dr. Edwin H. Ellison*, professor of surgery, and *Dr. Jay J. Jacoby*, professor of anesthesia, both of Marquette University School of Medicine, Milwaukee; and Dr. James M. Price, professor of surgery in cancer research, University of Wisconsin Medical Center, Madison.

The following officers were elected for 1961–1962: president—*Dr. James W. Sargent*, Milwaukee; vice-president—*Dr. John P. McCann*, La Crosse; and secretary - treasurer—*Dr. John T. Hotter*, Milwaukee.

The 35th annual meeting will be held in Madison on April 13–14, 1962.

Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology

Members of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology met April 15 and 16 at the Wausau Club in Wausau for a business and scientific meeting.

The program included the following:

"Ten Years' Experience with Industrial Audiometry" by Edward C. Riley, M.D., Eastman Kodak Co., Rochester, N.Y.

"New Techniques in Hearing Testing" by Claude Hayes, Ph.D. and John Peterson, Ph.D., University of Wisconsin, Madison.

"Retinal Detachment, Pathogenesis, Diagnosis and Prognosis" by *Mathew D. Davis, M.D.*, assistant clinical professor of surgery, University of Wisconsin Medical Center, Madison.

"Discussion of the above paper" by *Frederick A. Davis, M.D.*, professor of ophthalmology, emeritus, University of Wisconsin Medical Center, Madison.

"Principles of Treatment of Idiopathic Retinal Detachment" by Mathew D. Davis, M.D.

"Technique of Scleral Buckling Operation" (demonstrated with films) by Mathew D. Davis, M. D.

A luncheon given by Employers Mutual of Wausau was held April 15 at the Wausau Club, preceding the afternoon scientific session. That evening a dinner was held at Palm's Supper Club. The business session was held April 16 at the Employers Mutual of Wausau building.

Milwaukee Academy of Medicine

Dr. John A. Campbell of the Indiana School of Medicine was guest lecturer at the May 16 meeting of the Milwaukee Academy of Medicine. He is professor and chairman of the department of radiology. Doctor Campbell's subject was "The Clinical Application of Cineradiography."

Wisconsin Surgical Society

The spring meeting of the Wisconsin Surgical Society was held in Milwaukee on May 4 in conjunction with the annual State Medical Society meeting. The morning program was held at the Milwaukee Children's Hospital and the afternoon program at the Milwaukee Auditorium. *Dr. Peter Midelfart* was president of the Society.

New officers elected at the annual meeting are Doctors *Jack A. Killins*, Green Bay, president; *Anthony R. Curreri*, Madison, president-elect; *Norman O. Becker*, Fond du Lac, secretary–treasurer; *Jerry W. McRoberts*, Sheboygan, recorder. Doctors *Shimpei Sakaguchi*, Milwaukee, and *Victor S. Falk*, Edgerton, were elected to the Council of the Society for three-year terms. Other Council members are Doctors *William H. Frackelton*, Milwaukee; *Joseph J. Gramling, Jr.*, Milwaukee; *William H. Pollard, Jr.*, Beloit, and *Marvin H. Steen*, Oshkosh.

The Wisconsin Surgical Club made its annual spring tour the week of April 9. The tour included day-long visits to the National Naval Medical Center and the National Institutes of Health at Bethesda, Maryland, and to the Duke University Medical Center at Durham, North Carolina, and to the University of North Carolina Medical School at Chapel Hill. Members of the Surgical Club who made the trip were Doctors *Norman Becker* of Fond du Lac, *Warner Bump* of Rhinelander, *Conde Conroy, Joseph*

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Boston, 18, Mass.

SPECIALTY SOCIETIES *continued*

King and *C. Morrison Schroeder*, all of Milwaukee, *Joseph Gale* of Madison, *Sigurd Gundersen* of La Crosse, *Jack Killins* of Green Bay, *Victor Marshall* of Appleton, *Peter Midelfart* of Eau Claire and *Maurice Rice* of Stevens Point. Guests making the trip were Doctors *William Clark* of Oshkosh, *Victor Falk* of Edgerton, *Harold Gross* of Appleton, *Adolf Gundersen* of La Crosse, *James Sullivan* and *Albert Martin* of Milwaukee, *George Thuerer* of Rhinelander, and *Ernest Zmolek* of Oshkosh.

Milwaukee Gynecological Society

At the annual meeting of the Milwaukee Gynecological Society, held Monday, May 8, the following officers were elected: *Dr. George S. Kilkenny*, Milwaukee, president; *Dr. Robert E. McDonald*, Milwaukee, vice-president; *Dr. Lester H. Verch*, Milwaukee, will continue for one more year to complete his two-year term as secretary–treasurer.

Psychiatric Association Meeting

The Northern Wisconsin Chapter of the Wisconsin Psychiatric Association held its annual meeting June 17 and 18 at the Leatham Smith Lodge, Sturgeon Bay. An informal scientific program of general interest was presented. The president, *Dr. Keith Keane* of Appleton, made arrangements. Members toured the psychiatric unit of St. Vincent's Hospital in Green Bay.

for "All That's NEW in Medicine"

attend

annual Milwaukee Medical Conference

October 19–20, 1961

Wm. L. Coffey Auditorium
Milwaukee County Hospital

AN ENTERTAINING SOCIAL PROGRAM IS ALSO SCHEDULED FOR YOU AND YOUR WIFE . . . PLAN AN INFORMATIVE AND RELAXING "WEEKEND IN MILWAUKEE"

NEWS OF WISCONSIN PHYSICIANS

Dr. Sandmire County Society Speaker

Dr. Herbert F. Sandmire, obstetrician and gynecologist, Green Bay, addressed the Door—Kewaunee County Society meeting held March 28. His subject was entitled "The Incompetent Cervix as a Cause of Second Trimester Abortions and Premature Labor."

Dr. Beno Speaker at Michigan Meeting

Dr. Thomas J. Beno, Green Bay surgeon, was the guest speaker at the April meeting of the Dickinson County Medical Society in Iron Mountain, Michigan. The meeting was held April 13 at the Dickinson Hotel in Iron Mountain. The subject of his presentation was "Surgical Diseases of the Lungs."

Correction!

In the April issue there was an incorrect statement concerning the internship of *Dr. Rafael Barajas*, Waupun. His medical career includes the following: internship—Methodist Hospital, Madison; one year in general surgery—Methodist Hospital, Madison; three years in orthopedic surgery (A.F.C.)—St. Vincent's Hospital, Toledo, Ohio; two years in physical medicine and rehabilitation—Warm Springs Foundation, Warm Springs, Ga.

Doctor Hansen Locates at Janesville

Dr. Thomas R. Hansen, who has been a fellow in radiology in the Mayo Foundation, Rochester, Minn., has left that city and is now located in Janesville.

Dr. John Allen Addresses Rotary Club

Dr. John Allen, medical consultant to the State Department of Public Welfare, Madison, addressed the Oregon Rotary Club on May 29. His subject was "Medical Care for the Aged; How Should It Be Financed?". The material presented outlined the AMA's policies for providing care for those in need and voluntary health insurance coverage for those able to pay.

Doctor Banyai Guest Speaker

Dr. Andrew L. Banyai, Chicago, Ill., was the guest speaker at the annual meeting of the Georgia Chapter of the American College of Chest Physicians held at Atlanta, Ga., on May 8. The subject of his talk was Pulmonary Diseases Due to Air Pollution. On the same day, he gave a lecture on the Pathogenesis and Treatment of Pulmonary Emphysema at the annual convention of the Medical Association of Georgia and was one of the participants of a clinical x-ray panel on chest diseases. Doctor Banyai is clinical professor of medicine, emeritus, Marquette University School of Medicine, Milwaukee.

Physicians whose names appear in italic are members of the State Medical Society.

Physicians Certified in OB–GYN

Nine Wisconsin physicians were certified in the specialty of Obstetrics and Gynecology on April 15. Certifications following examination are made once a year by the American Board of Obstetrics and Gynecology. Those certified are: Doctors *A. C. Alexander*, Racine; *T. S. Arnold*, Manitowoc; *R. F. Barta*, Milwaukee; *D. V. Foley*, Milwaukee; *N. M. Hilrich*, Milwaukee; *W. A. Kretzschmar*, Milwaukee; *W. J. Madden*, Racine; *R. P. Reik*, Milwaukee, and *E. Y. Strawn*, Milwaukee.

MacCornacks, Whitehall, Honored

The Hutchins–Stendahl Post of the American Legion, Whitehall, sponsored a MacCornack Day June 11 honoring *Dr.* and Mrs. *R. L. MacCornack, Sr.* Festivities included a picnic dinner, band concert and program.

Guests signed registration books which were handled by the Whitehall Girl Scouts. A special registration book was provided for "Doctor Mac Babies."

Other local organizations which cooperated with the Legion Post were the Boy and Girl Scouts, the Chamber of Commerce, the Lions Club, and Whitehall Golf Club.

Besides being family doctor to area families, Doctor MacCornack has worked as a civic leader in Whitehall. Mrs. MacCornack has also been a civic worker for the city.

Wisconsin Physicians Fellows in ACOG

Twelve Wisconsin physicians were among the 473 new Fellows recently inducted by the American College of Obstetricians and Gynecologists at a formal ceremony held during the tenth anniversary meeting, April 20–28, at Bal Harbor, Fla.

To become a Fellow of ACOG a physician must have completed an approved program of medical training, limited his practice completely to obstetrics and gynecology for at least five years, and have the unqualified professional approval of his colleagues. The College now has 6,960 Fellows, including Life, Associate and Junior.

The new Wisconsin Fellows are: *Dr. George J. Theiler*, Green Bay; *Dr. Ralph F. Sortor*, Hales Corners; *Dr. Robert A. Holland*, Janesville; *Dr. Rudolf E. Schuldes*, La Crosse; *Dr. John G. Webster*, Manitowoc; *Drs. Emil J. Drvaric, William A. Kretzschmar, Gerald L. Mullaney, L. J. Paquette, Samuel G. Perlson*, and *Dean P. Spyres*, all of Milwaukee; and *Dr. A. C. Alexander*, Racine.

SOCIETY RECORDS

NEW MEMBERS

David R. Downs, M.D., Dodgeville.
Darrell L. Link, M.D., 1200 Lakeshore Drive, Beaver Dam.
Eleanor C. Struck, M.D., Route 1, Box 153, West Bend.
William A. Conn, M.D., 139½ South Main, Shawano.
Glenn C. Hillery, M.D., 254 South Harrison, Lancaster.
Mark F. Backs, M.D., 2707 Marshall Court, Madison 5.
Noe Neaves, M.D., Mendota State Hospital, Madison.
Donald W. Price, M.D., 5718 Cedar Place, Madison.
William Klumper, M.D., 5101 Sherwood Road, Madison.
Glen G. Cramer, M.D., Osceola Clinic, Osceola.
Robert A. Dye, M.D., 650 Central Avenue, Marshfield.
Robert M. Heywood, M.D., 650 S. Central Avenue, Marshfield.
Richard L. James, M.D., P.O. Box 57, Valders.
Joseph J. Skemp, M.D, 312 State Street, La Crosse.
Bernard Kalfayan, M.D., 1836 South Avenue, La Crosse.
Jordan H. Fink, M.D., 7801 West Hampton, Milwaukee.
Francis J. Kozina, M.D., 4211 West North Avenue, Milwaukee.
Asher L. M. Cornfield, M.D., 5022 West Hampton Avenue, Milwaukee.
Robert J. Goldberger, M.D., Milwaukee County Hospital, Milwaukee.
Ernest O. Henschel, M.D., Milwaukee County Hospital, Milwaukee.
Burton J. Friedman, M.D., 815 East Kensington Boulevard, Milwaukee.
Guy W. Holmes, M.D., VA Hospital, Wood.
Roger L. Hepperla, M.D., 4300 N. 84th Street, Milwaukee.
Bernard J. Klamecki, M.D., 625 North Milwaukee Street, Milwaukee.
Richard. R. Byrne, M.D., 3321 North Maryland Avenue, Milwaukee.
Donald E. Gunderson, M.D., 3183 N. 106th Street, Wauwatosa.
James T. Botticelli, M.D., 8700 West Wisconsin Avenue, Milwaukee.
Roland E. Berry, M.D., VA Hospital, Wood.
Bruce Bogost, M.D., 242 East Chareau Place, Milwaukee.
William R. Mills, M.D, 4835 West Capitol Drive, Milwaukee.
Walter Lee Modaff, M.D., 556 North 63rd Street, Wauwatosa.
Michael A. Polacek, M.D., VA Hospital, Wood.
Ingrida E. Raits, M.D., 2040 West Wisconsin Avenue, Milwaukee.
Richard H. Patterson, M.D., 1220 Dewey Street, Wauwatosa.
James P. Rowan, M.D., 3467 South Kinnickinnic Avenue, Milwaukee.
Samuel R. McCreedie, M.D., 1700 Wisconsin Avenue, Milwaukee.
Carl F. Schmidt, M.D., 1024 East State Street, Milwaukee.
Ferdinand J. Vlazny, M.D., 2729 East Capitol Drive, Shorewood.
Milton C. Bessire, M.D., Box 3128, Madison.
Vaughn Demergian, M.D., 30 South Henry Street, Madison.
Martin A. Rammer Jr., M.D., 2617 East Johnson Street, Madison.
Albert J. Blair, M.D., 1300 University Avenue, Madison.

CHANGE OF ADDRESS

J. J. Mulvaney, M.D., Wausau, to 60 13th Street, Clintonville.
R. Kenneth Loeffler, M.D., Madison, to 430 Lake Avenue N.E., Massillon, Ohio.
Mildred M. Stone, M.D., Madison, to 209 W. Clemens Street, Cuba City.
Rafael Barajas, M.D., Brillion, to Waupun Clinic, Waupun.
Donald P. Gruendel, M.D., Milwaukee, to 4816 Sunset Boulevard, Tampa, Florida.
John P. Locksmith, M.D., Texas, to 2400 N. Main Street, Clouis, New Mexico.
Wallace S. Marshall, M.D., Watertown, to Florala, Alabama.
Frank A. Neisius, M.D., Oregon, to 620 East Washington, Stayton, Oregon.
H. K. Rosmann, M.D., Cuba City, to Route 1, Box 188A, Hayward.
Martin J. Denio Jr., M.D., Wauwatosa, to 1735 Wedgewood West, Box 546, Elm Grove.
R. L. Mac Cornack, M.D., Phoenix, Arizona, to Whitehall.
Harland Levin, M.D., Delavan, to 60 South Main Street, Janesville.
Gregory Inda, M.D., Brookfield, to 8500 West North Avenue, Wauwatosa.
John A. Van Susteren, M.D., Sparta, to Route 1, Box 238, Onalaska.
Theodore R. Draelos, M.D., Milwaukee, to Dugway Proving Grounds, Dugway, Utah.
Frank F. Gollin, M.D., LaFarge, to 1408 Elmwood Street, Middleton.
Boyd F. Nirschl, M.D., 156 East Chateau Place, Milwaukee.
F. C. Kinsman, M.D., 1414 Rust Street, Eau Claire.
V. N. Vitulli, M.D., 2956 A North 50 Street, Milwaukee 10.
J. A. Tasche, M.D., 4211 Birch Drive, Sheboygan.
R. M. Kurten, M.D., 3047 Ruby Street, Racine.
W. J. Smollen, M.D., 114 7th Street, Racine.
C. R. Pearson, M.D., Box 374, Baraboo.
J. W. Bringe, M.D., 3708 North 7th, Sheboygan.

William D. Brand, M.D., 238 West Wisconsin Avenue, Milwaukee.
Ernest S. Olson, M.D., 1728 Carlisle Avenue, Racine.
William J. Madden, M.D., 810 Main, Racine.
Robert F. Scheller, M.D., 807 16th Street, Racine.
John D. Owen, M.D., 2266 North Prospect Avenue, Milwaukee 2.
Carl F. Glienke, M.D., 2266 N. Prospect Avenue, Milwaukee.
Haydon R. Duffy, M.D., 8418 West Congress, Milwaukee 18.
Marvin Wright, M.D., 114 N. Oneida Avenue, Rhinelander.
Arthur Chandler, M.D., 1726 Country Lane, Monroe.
Stanley E. Zawodny, M.D., 5820 W. Forest Home Avenue, Milwaukee.
Robert R. Brazy, M.D., 2147 West Skyline Road, Milwaukee.
Thomas F. Garland, M.D., 9008 W. Burleigh Street, Milwaukee.
Daniel K. Schmidt, M.D., 5148 N. Teutonia Avenue, Milwaukee.
Clyde W. Yellick, M.D., 2266 N. Prospect Avenue, Milwaukee.
Jerry H. Jascula, M.D., 4211 N. Prospect Avenue, Milwaukee.
Donald A. Roth, M.D., 1620 Revere Drive, Brookfield.
Rudolph J. Scrimenti, M.D., 3267 N. 52nd Street, Milwaukee.
Samuel G. Perlson, M.D., 425 East Wisconsin Avenue, Milwaukee.
Harry P. Maxwell, M.D., 2266 North Prospect Avenue, Milwaukee.
William H. Frackelton, M.D., 2266 North Prospect Avenue, Milwaukee.
Jack L. Teasley, M.D., 2266 North Prospect Avenue, Milwaukee.
H. W. Hoegemeier, M.D., 1551 Dousman Street, Green Bay.
R. F. Johnston, M.D., 1551 Dousman Street, Green Bay.
M. S. LeTellier, M.D., 1551 Dousman Street, Green Bay.
W. M. Stoll, M.D., 1551 Dousman Street, Green Bay.
E. S. Brusky, M.D., 1551 Dousman Street, Green Bay.
M. A. Warpinsky, M.D., 1551 Dousman Street, Green Bay.
G. E. LeMieux, M.D., 1551 Dousman Street, Green Bay.
S. F. Brusky, M.D., 1551 Dousman Street, Green Bay.
Lloyd B. McCabe, M.D., 97th General Hospital, 757 New York, New York.
Loren E. Hart, M.D., St. Mary's Hospital, Green Bay.
J. E. Abrams, Milwaukee, to 5900 South Lake Drive, Cudahy.
R. M. Rogers, Whitehall, to 7259 West Lakefield Avenue, Milwaukee 19.
C. F. Hutson, M.D., 224 West Washington Avenue, Madison 3.
L. E. Miller, M.D., 3525 South 76th Street, West Allis.
Thomas W. Dorman, M.D., 2908 Taylor, Racine.
Benward L. Chapman, M.D., 1124 West State Street, Milwaukee.
George E. Collentine, Jr., M.D., 2266 N. Prospect Avenue, Milwaukee.
John D. Conway, M.D., 2266 N. Prospect Avenue, Milwaukee.
Arnold N. Elconin, M.D., 1124 West State Street, Milwaukee.
Michael S. Nefches, M.D., 5930 West Burnham Street, Milwaukee.
David W. Ovitt, M.D., 2266 N. Prospect Avenue, Milwaukee.
Paul W. Ryan, M.D., 2266 N. Prospect Avenue, Milwaukee.
Dexter H. Witte, M.D., 2266 N. Prospect Avenue, Milwaukee.
Henry O. McMahon, M.D., 8045 North Green Bay Road, Milwaukee.
H. Gladys Spear, M.D., 1610 N. Prospect Avenue, Milwaukee.
Thomas F. McCormick, M.D., 2634 North Murray Avenue, Milwaukee.
David Cole, M.D., 328 Blackburn Street, Ripon.
William H. Dohearty, M.D., 7236 Milwaukee Avenue, Wauwatosa 13.
T. F. Farrell, M.D., Farrell Clinic, 610 East Taylor, Prairie du Chien.
Verne C. Epley, M.D., Farrell Clinic, 610 East Taylor, Prairie du Chien.
Michael S. Garrity, M.D., Farrell Clinic, 610 East Taylor, Prairie du Chien.

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annual
Milwaukee
Medical
Conference

October 19–20, 1961
Wm. L. Coffey Memorial Auditorium
Milwaukee County Hospital

RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Madison, January 11, 1961.

Name	*School of Graduation*	*Year*	*City*
Backs, M. F., M.D.	Loyola University	1952	Madison
Baumann, P. A., M.D.	University of Wisconsin	1957	West Allis
Brew, Barbara A., M.D.	Woman's Med. College	1953	Madison
Cannavos, C. D., M.D.	University of Athens	1950	Chicago
Cant, W. F., M.D.	University of Illinois	1957	Milwaukee
Carlson, E. V., M.D.	University of Nebraska	1956	Milwaukee
Fitz, A. E., M.D.	University of Michigan	1959	Milwaukee
George, Konstantine, M.D.	University of Athens	1953	Milwaukee
Gilbert, Francis, M.D.	Boston University	1955	Waukesha
Hansen, T. R., M.D.	University of Illinois	1954	Rochester, Minnesota
Higgins, C. K., M.D.	Washington University	1927	La Crosse
Hoegemeier, H. W., M.D.	University of Indiana	1950	Green Bay
McNelis, D. P., M.D.	University of Ireland	1946	Milwaukee
Palmer, K. A., M.D.	University of Minnesota	1955	Menomonie
Petersen, R. E., M.D.	University of Iowa	1943	Cuba City
Peterson, C. E., M.D.	University of Rochester	1927	Kenosha
Rian, Oliver, M.D.	Marquette University	1935	Peoria, Illinois
Rutledge, P. E., M.D.	St. Louis University	1927	Washington Island
Saletta, C. A., M.D.	Chicago Medical College	1935	Chicago, Illinois
Schulz, Emil, M.D.	University of Minnesota	1956	Eau Claire
Setler, S. H., Jr., M.D.	Meharry Medical College	1959	Milwaukee
Telford, J. G., M.D.	Northwestern University	1959	Washburn
Wessel, H. U., M.D.	Albert Ludwigs University	1953	Evanston, Illinois

Prenatal Facts

SUGGESTED PROCEDURE — **File at hospital in last month of pregnancy. If there are indications of possible premature delivery file earlier. Direct this form to the supervisor of obstetrics of the hospital to which the patient will be admitted.**

Name _____ **Address** _____ **igion** _____

Expected date of confinement _____ **-- Para** _____

Number of abortions _____ **miscarria** **del.** _____

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Date of visi

Weight

Heart

FOR YOUR CONVENIENCE, DOCTOR . . .

The Division on Maternal and Child Welfare has prepared a sheet which is recommended for use by all Wisconsin physicians in reference to hospital care of obstetrical patients . . .

You will find this of convenience to you, and of much value to your obstetrical patients. It will alert the hospital to proper care when your patient is admitted for delivery.

Per pad of 100 forms—$2.00.

Write:
DIVISION ON MATERNAL AND CHILD WELFARE
State Medical Society of Wisconsin
Box 1109, Madison 1, Wisconsin

STATE MEDICAL SOCIETY OF WISCONSIN
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NEWS FROM THE MEDICAL SCHOOLS

UW Field Day Awards

Fifteen medical students received awards and scholarships April 27 at the annual University of Wisconsin Medical School Field Day. The awards honored the students for independent study and research during their undergraduate years and for superior scholastic ability.

The Borden Award, for undergraduate research in medicine, was given to John C. Leissring, senior, Milwaukee.

The Theobald Smith Award, established in 1956 by a gift from Dr. Paul F. Clark, emeritus professor of microbiology, for a medical student who completes an outstanding paper of original research in the field of microbiology, went to Leonard P. Merkow, junior, Milwaukee.

The William J. Bleckwenn, Jr. Award, given to the senior student showing the most clinical promise, went to Kenneth M. Oberheu, Cedarburg.

The Roche Award, for the student who in the opinion of the faculty best exemplifies ideals of the modern physician, was given to James H. Thomsen, junior, Denmark, Wis.

The Bardeen Award, established by Alpha Psi Chapter of Phi Delta Epsilon in honor of Charles R. Bardeen, professor of Anatomy and first dean of the medical school, was awarded to the student doing the best work in anatomy during the freshman year, Adolph M. Hutter, Jr., Fond du Lac.

The Lewis E. and Edith Phillips Awards for superior scholastic ability went to Robert D. Heinen, freshmen, Oostburg, George A. McAuley, Jr., sophomore, Madison, and James L. Basiliere, junior, Oshkosh.

The Mosby Awards, to five sophomores with high scholastic standings, went to Leslie Baer, New York City, Christian L. Gulbrandsen, Viroqua, Adolph Hutter, Jr., Fond du Lac, David Mathison, Milwaukee, and Timm A. Zimmerman, Sheboygan.

Two Wisconsin Foundation Medical Scholarships went to freshmen Andrew Horvath, Providence, N.J., and David M. Jaecks, West Allis.

Dr. Waisman to Direct Kennedy Grant

Dr. Harry A. Waisman, professor of pediatrics at the University of Wisconsin Medical School, has been concerned with the study of mental retardation due to "inborn errors" of metabolism since 1956. Prior to that time, he worked on cancer and leukemia in children. His mental retardation research has centered chiefly around the hereditary disease phenylketonuria (PKU) which produces mental retardation.

Since 1956, Doctor Waisman has examined all mentally retarded children in state institutions for whom the cause of retardation was unknown. By use of a simple urine test, he found 55 who showed symptoms of PKU. Although little could be done for these chil-

University of Wisconsin medical students who received awards and scholarships April 27 at the annual Medical School Field Day are shown above following the presentation ceremony. Bottom row, left to right, are: James Basiliere, Oshkosh, Lewis E. and Edith Phillips Award; James H. Thomsen, Denmark, Wis., Roche Award; John C. Leissring, Milwaukee, Borden Award; Timm A. Zimmerman, Sheboygan, Mosby Award; Christian Gulbrandsen, Viroqua, Mosby Award; and David Mathison, Milwaukee, Mosby Award. Middle row: Leonard P. Merkow, Milwaukee, Theobald Smith Award; and Kenneth Oberheu, Cedarburg, Wm. J. Bleckwenn Jr. Award. Top row: David Jaecks, West Allis, Wisconsin Foundation Medical Scholarship; Robert Heinen, Oostburg, Phillips Award; Adolph M. Hutter, Jr., Fond du Lac, Bardeen Award and Mosby Award; Andrew Horvath, New Providence, N. J., Wisconsin Foundation Medical Scholarship; George A. McAuley, Jr., Madison, Phillips Award; and Leslie Baer, New York City, Mosby Award.

dren, they led him to their families, in which other phenylketonuritic children might be born.

He initiated a treatment program in 1957 for children in whom the disease was diagnosed in the first few weeks of life, again by use of the urine test. He started the infants on a low-phenylalanine diet of milk powder. This is dissolved in water and fed like any other formula; it allows good growth, good bone formation, and attainment of most skills if followed rigorously.

(Duane Hopp Photo)

Mrs. R. Sargent Shriver, Jr., sister of President Kennedy, presents a $225,000 medical research grant to Dr. Harry A. Waisman, professor of pediatrics, University of Wisconsin Medical School. The grant from the Joseph P. Kennedy Jr., Foundation, presented April 27 in the office of Dr. John Z. Bowers, dean of the UW Medical School, will help pay the cost of erecting an additional floor at Children's Hospital at the UW Medical Center and will support expanded research into mental retardation under direction of Doctor Waisman.

Another research project is to try to understand enzymes in the brain and how they function in normal workings of the brain.

Doctor Waisman's associates in these studies are Dr. Theo Gerritsen, Dr. Hwa Lih Wang, Dr. Robert H. Weaver, Dr. Lynnette H. Doeg, Dr. V. R. Harwalker, Dr. V. J. Polidora, Phyllis Berman, Gail Palmer, Chris Ripp, and Mary Blankenheim.

Ohio Psychiatrist Speaks on Mental Illness

A psychiatrist who studies the incidence and prevalence of mental illness reported April 19 that his special branch of science—epidemiology—is dissatisfied with information it is getting from surveys and studies.

Dr. Benjamin Pasamanick, director of research for the department of psychiatry at Ohio State University Medical School, spoke in a series of lectures sponsored by the University of Wisconsin department of preventive medicine. He spoke to about 130 students and faculty in Service Memorial Auditorium.

Dr. Pasamanick said unreliable interview studies and unreliable diagnoses of mental illness have resulted in unreliable information about the mental health situation.

He said electronic computers might be used to weed out masses of information and get at some predictive items for diagnoses. Recent studies of schizophrenia which compared different kinds of twins implied that information on mental diseases might be obtained from studying hereditary factors, he said.

Prenatal care, extent of education and other social and economic factors have to be considered carefully before any statements can be made about the comparative mental health of any group of people, he said.

Receive Honors at UW Alumni Day

Dr. Milton J. E. Senn, director of the Child Study Center and Sterling Professor of Pediatrics and Psychiatry at Yale University, received the 1961 Medical Alumni Citation of the University of Wisconsin Medical Alumni Association. The award was presented at the UW Medical School's "Alumni Day" May 19.

Doctor Senn, a member of the medical school's first graduating class, was honored for "achievements in the practice of medicine, in academic activities, and in research accomplishments."

For the past 25 years, he has successfully interpreted medical psychology and psychiatry to nonpsychiatric physicians, particularly general practitioners and pediatricians. As director of the Yale Child Study Center since 1948, he has fostered research in child development as a basic science for child care practices.

Milwaukee-born Doctor Senn received his B.A. degree from Wisconsin in 1925 and his M.D. in 1927.

Dr. Paul F. Clark, emeritus professor of medical microbiology at the University of Wisconsin Medical School, received the 1961 Emeritus Faculty Award of the UW Medical Alumni Association on its annual "Alumni Day" May 19.

Doctor Clark, who received his Ph.D. from Brown University, was on the medical school faculty as chairman of the medical microbiology department from 1914 to his retirement in 1952. His retirement by no means signaled the end of his research activities.

He has been especially concerned with virus research and devoted much time to investigations on the polio virus. He has also done research on microbes causing diphtheria, dysentary, and pneumonia.

Three Medical Educators Retire in June

An "ideal surgeon," who is said to actually stimulate patients to get well, retires in June as chairman of the surgery department at the University of Wisconsin Medical School. Dr. Erwin Rudolph Schmidt has been a doctor for 45 years and head of the surgery department for 35.

His quiet dignity, his excellent technical knowledge of surgery, his kindness to patients, and his calm disposition even in times of stress explain why his associates have dubbed him the "great white father."

E. R. Schmidt, M. D.

Among achievements in the surgery department through the years was creation in 1928 of the first department of anesthesiology in the country.

The high regard in which his associates and former students hold him was shown in 1951 on his 25th anniversary as surgery chairman. Twenty-nine of the 44 surgeons he had trained up to that time honored him at a dinner. They presented him with a sterling silver tray bearing 44 names.

In October, 1949, after he had served for 10 years as a member of the Council of the Wisconsin State Medical Society, Doctor Schmidt received the Council Award, the highest honor the society confers.

E. A. Pohle, M. D.

A man who pioneered the use of radiation for medical therapy retires from the University of Wisconsin faculty this June.

He is Dr. Ernst Albert Pohle, one of the first doctors to use geiger counters to measure radiation dosage in medical therapy. This helped put dosage measurement on an accurate and scientific basis.

During his long career, the German born scientist has been an outstanding scientific researcher, medical therapist, administrator, and prolific writer. Dr. Wayne Rounds, Madison physician and colleague of Doctor Pohle, calls him "an excellent teacher of radiology to his residents and fellow doctors." He was chairman of the UW radiology department from 1928 to 1957.

Doctor Pohle came to the UW Medical School in 1928, and soon thereafter established Madison as one of the first centers for radiation therapy and the University as one of the few institutions producing radon "seeds" for this therapy.

Doctor Pohle was instrumental in setting up a million-volt X-ray machine at the University in 1951, and it has proved extremely useful in cancer therapy.

Forty-one years ago, Dr. Frederick D. Geist left Boston and came to the University of Wisconsin Medical School as an instructor in anatomy. When he retires in June, Doctor Geist will complete the longest period of service of any faculty member in the Department of Anatomy since the UW Medical School was established in 1907.

F. D. Geist, M. D.

Throughout the years, his academic accent has been on practicality. "What I have tried to do, in addition to teaching basic anatomy," Doctor Geist said, "is to give these medical students the practical applications of what they are learning."

About eight years ago, Doctor Geist was in part responsible for a significant change in the teaching of anatomy at Wisconsin. First-year medical students were required to take clinical, as well as the basic theoretical sessions in neuro-anatomy. For the first time here, classroom neuro-anatomy came to life in Saturday morning clinics.

His special academic interests have been in neurology and in the application of basic anatomical sciences.

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MEDICAL MEETINGS—POSTGRADUATE COURSES

American Cancer Society Session

The 1961 scientific session of the American Cancer Society will be held October 23–24 at the Biltmore Hotel in New York City. The topic is: THE PHYSICIAN AND THE TOTAL CARE OF THE CANCER PATIENT. For further information write: Professional Education Section, American Cancer Society, 521 West 57 Street, New York 19, N.Y.

Three Wisconsin physicians are on the program. Dr. Anthony R. Curreri, professor of surgery and director of the Cancer Research Hospital, University of Wisconsin Medical Center, Madison, will discuss the "Role of Chemotherapy—Systemic" as part of the program on "Care of the Advanced Cancer Patient." On the same program will be Dr. Jay J. Jacoby, professor and chairman of the department of anesthesiology, Marquette University School of Medicine, Milwaukee, who will discuss "Pain Control."

Dr. John S. Hirschboeck, Dean, Marquette University School of Medicine, Milwaukee, will preside at a session on "Society's Role in Caring for the Cancer Patient."

Inter-Disciplinary Research Conference

The Wisconsin Psychiatric Institute and the Department of Psychiatry, University of Wisconsin Medical Center, Madison, will sponsor a three-day inter-disciplinary research conference August 29–31 on "The Physiological Correlates of Psychological Disorders." A partial list of speakers who will present formal papers includes: Albert Ax, Ph. D.; Albert DiMascio, M.A.; John Lovett Doust, M.D.; David T. Graham, M.D.; Milton Greenblatt, M.D.; Joseph H. Handlon, M.D.; Herbert Leiderman, M.D.; Thomas H. Holmes, M.D.; Donald Oken, M.D.; Harold Persky, Ph.D.; William Pollin, M.D.; Charles Shagass, M.D.; Albert Stunkard, M.D.; Garfield Tourney, M.D.; Herbert Weiner, M.D., and Marion Wenger, Ph.D.

Topics will include: adrenocortical function during anxiety, methodological and theoretical problems in psychophysiological research, psychophysiological phenomena in resistance to infection, psychological factors in cardiovascular responses, and others.

Housing will be arranged to encourage informal interaction among the speakers and participants. Accommodations will be in lake front dormitories with facilities for a full range of summer activities. Interested scientists and their families are cordially invited. Inquiries may be addressed to: Dr. Norman S. Greenfield, Conference Co-Director, Department of Psychiatry, University Hospitals, Madison 6, Wisconsin.

Wisconsin Academy of General Practice

Thirteenth annual scientific assembly will be held September 18 and 19 at the Milwaukee Auditorium. Details will be published next month.

WISCONSIN CALENDAR COMING EVENTS

1961

June 26–30: AMA Annual Meeting, New York, New York.

July 28–29: SMS Council meeting, Land O' Lakes.

Aug. 29–31: UW Postgraduate course, Psychiatric symposium, Dr. R. Roessler, chrm., Wisconsin Center Building, Madison.

Sept. 13: Special Conference on Problems of the Newborn, St. Mary's Hospital, Wausau.

Sept. 28–30: UW postgraduate course, Anesthesiology, Dr. O. S. Orth, chrm., University Hospitals, Madison.

Oct. 13–14: UW postgraduate course, Psychiatry, Dr. R. Roessler, chrm., Wisconsin Center Building, Madison.

Oct. 19–20: Milwaukee Medical Conference, Milwaukee County Hospital.

Oct. 23–24: Scientific session, American Cancer Society, New York City.

Nov. 13–17: Annual meeting, American Public Health Association, Detroit, Mich.

Nov. 16–18: UW postgraduate course, Rehabilitation of Patients with Injuries of the Spinal Cord, Dr. A. Siebens, chrm., Wisconsin Center Building, Madison.

Nov. 28–Dec. 1: AMA Clinical Meeting, Denver, Colorado.

1962

Apr. 5–7: UW postgraduate course, Genetics in Pediatrics, Drs. J. Crow and N. Smith, co-chrm., Wisconsin Center Building, Madison.

Apr. 26–28: UW postgraduate course, Psychosomatic Medicine, Dr. David Graham, chrm., Wisconsin Center Building, Madison.

May 8–10: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 10–11: UW postgraduate course, Orthopedic Surgery, Dr. H. Wirka, chrm., Wisconsin Center Building, Madison.

May 17–19: UW postgraduate course, Anatomy, Physiology and Pathology of the Holocrine, Apocrine and Eccrine Glands, Dr. S. Johnson, chrm., Wisconsin Center Building, Madison.

June 11–15: AMA Annual Meeting, Chicago, Illinois.

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California.

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20th ANNIVERSARY 1941 1961

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

NEW BOOKS RECEIVED

CIBA FOUNDATION SYMPOSIUM AND COMMITTEE FOR SYMPOSIA ON DRUG ACTION ON ADRENERGIC MECHANISMS

Edited by J. R. Vane, B. Sc., D. Phil., for the British Pharmacological Society; G. E. W. Wolstenholme, M. D., M. B., M. R. C. P., and Maeve O'Connor, B. A. Little, Brown & Co., Boston, Mass., 1960. 632 pages. Price: $12.50.

METABOLIC EFFECTS OF ADRENAL HORMONES; CIBA FOUNDATION STUDY GROUP NO. 6.

In honour of Prof. G. W. Thorn. Edited by G. E. W. Wolstenholme, M.D., M.B., M.R.C.P., and Maeve O'Connor, B.A. Little, Brown & Co., Boston, Mass., 1960. 109 pages.

THE FAMILY HANDBOOK OF HOME NURSING AND MEDICAL CARE

By I. J. Rossman, M.D., Ph.D., Chief of Professional Services, Home Care Dept., Montefiore, Hospital, New York; and Doris R. Schwartz, R.N., Assistant Professor, Outpatient Nursing, Cornell University–New York Hospital School of Nursing, New York. Dolphin Books, Doubleday & Co., Inc., Garden City, New York, 1958. 519 pages. Price: $1.45.

CLINICAL OBSTETRICS AND GYNECOLOGY, VOL. 4, NO. 1

Obstetric Anesthesia and Analgesia. Edited by Robert A. Hingson, M.D., Professor, Department of Anesthesia, University Hospitals of Cleveland, Ohio. Vaginal Surgery. Edited by Abraham F. Lash, M.D., Ph.D., Clinical Professor, Obstetrics and Gynecology, University of Illinois College of Medicine. Paul B. Hoeber, Inc., New York, March 1961. 304 pages. Subscription price: $18.00/year.

INFORMATION PLEASE!

Including the Dunhill Chart; a Rhythm Method of Birth Control. By Alfred Dreyfus II. Vantage Press, New York, 1961. 556 pages. Price: $7.50.

LOSE WEIGHT AND LIVE

By Robert P. Goldman. Doubleday & Co., Inc., Garden City, New York, 1961. 235 pages. Price: $3.95.

W. B. SAUNDERS COMPANY

features the following recent books in their full page advertisement appearing elsewhere in this issue:

WHITE—CLINICAL DISTURBANCES OF RENAL FUNCTION—Diagnosis and treatment measures for kidney disorders

RUBIN—THORACIC DISEASES—Covers both medical and surgical management

MAYO CLINIC—DIET MANUAL—Recent advances in food, vitamin and dietary practice

THE CHANGING YEARS

The Menopause without Fear. By Madeline Gray. Revised ed. Dolphin Books, Doubleday & Co., Inc., Garden City, New York, 1958. 273 pages. Price: 95¢.

CHILDBIRTH WITH HYPNOSIS

By William S. Kroger, M.D.; edited by Jules Steinberg. Doubleday & Co., Inc., Garden City, New York, 1961. 216 pages. Price: $3.95.

MIRAGE OF HEALTH

Utopias, Progress and Biological Change. By Rene Dubos. Anchor Books, Doubleday & Co., Inc., Garden City, New York, 1961. 235 pages. Price: 95¢.

MANAGEMENT OF HYPERTENSIVE DISEASES

By Joseph C. Edwards, M.D., F.A.C.P., F.A.C.C., Assistant Professor, Clinical Medicine, Cardiovascular Consultant to Division of Gerontology, and Consultant in Hypertension and Cardiac Clinics, Washington University School of Medicine, St. Louis, Mo. C. V. Mosby Co., St. Louis, Mo., 1960. 439 pages. Price: $15.00.

BOOK REVIEWS

PHYSIOLOGY OF SPINAL ANESTHESIA

By Nicholas M. Greene, B.S., M.A., M.D., Professor of Anesthesiology and Lecturer in Pharmacology, Yale University School of Medicine; Director of Anesthesia, Grace–New Haven Community Hospital. The Williams & Wilkins Company, Baltimore. 1958. 195 pages. Price: $9.00.

Much has been written about the technique of administration of spinal anesthesia. In this book emphasis is placed upon the physiological effects of spinal anesthesia. Each chapter is devoted to the effects on a particular system such as the central nervous system, cardiovascular system, pulmonary ventilation and hemodynamics, hepatic function and renal function. Each of these sections constitutes an excellent review of the extensive literature on these subjects.

In addition to reviewing the literature, Doctor Greene has added comments and short summaries relating the clinical implications to these theoretical effects of spinal anesthesia. In the chapter concerned with the effects of spinal anesthesia upon the cardiovascular system, the arterial and arteriolar circulation, the post arteriolar circulation, the venous circulation, cardiac function and hypotension are discussed at length. The problem of the treatment of hypotension occurring during spinal anesthesia is well presented and there is an excellent discussion

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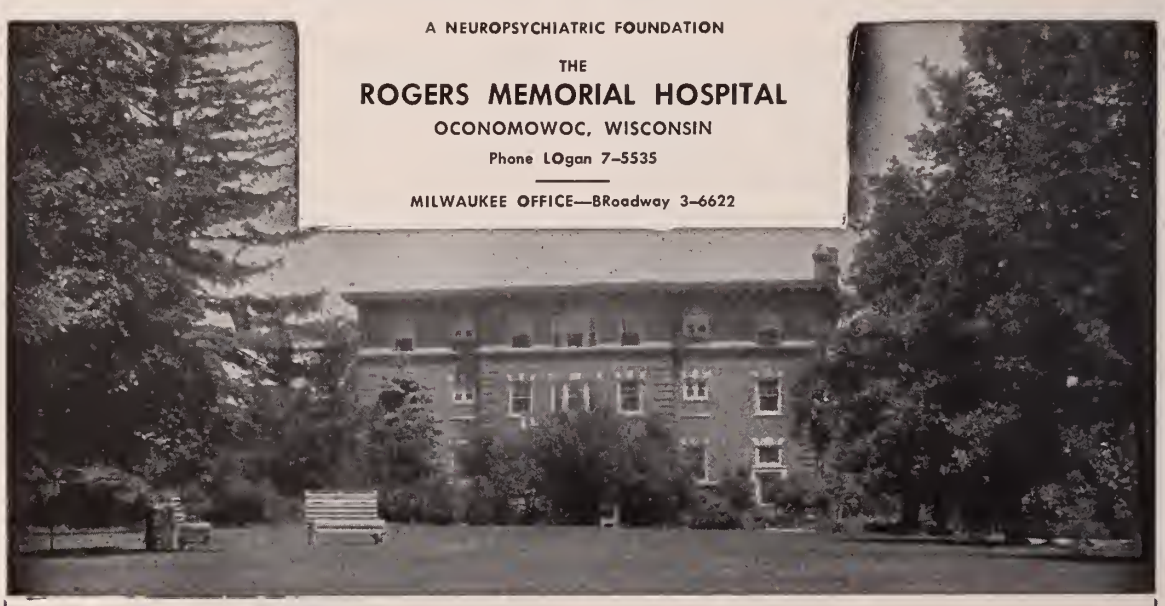

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explaining the usual bradycardia observed during high levels of spinal anesthesia.

Another valuable section of this book is concerned with the effects of spinal anesthesia on the altered physiology of the obstetrical patient. Although spinal anesthesia can so easily be administered, it is not free of hazard. The author feels that maternal death due to spinal anesthesia can be prevented only by full understanding of the pharmacological and physiological principles behind the method The abnormally great hemodynamic instability of the pregnant woman makes for much greater difficulty in control of the level of anesthesia and in management of blood pressure.

This book is interesting reading for anyone who may be concerned with the administration of anesthetics or to whose patients anesthetics may be given. Greater understanding of the usual and sometimes potentially dangerous effects of spinal anesthesia, and methods of treating these complications will render the technique safer for those patients to whom it is given.—BETTY J. BAMFORTH, M.D.

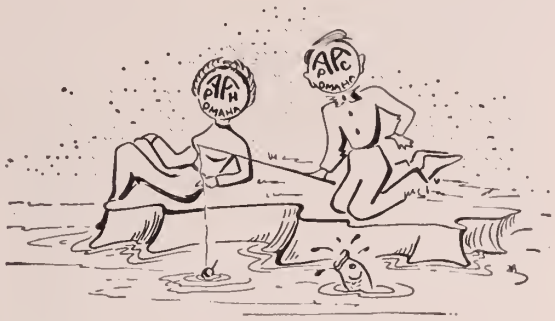
SYNOPSIS OF OPHTHALMOLOGY

By William H. Havener, B.A., M.D., M.S. (Ophth.) Professor and Chairman, Department of Ophthalmology, Ohio State University; Member, Attending Staff, University Hospital, Columbus, Ohio; Consulting Staff, Children's Hospital and Mt. Carmel Hospital, Columbus, Ohio. The C. V. Mosby Company. 1959. St. Louis. 288 pages. Price: $6.75.

Considering the inherent difficulties in writing any synopsis, this volume does a reasonably good job. The chapters on eye injuries and medical ophthalmology are outstanding. The chapters on eye examination and neuro-ophthalmology, however, do not come up to the caliber of other chapters. The author fails to discuss the measurement of visual acuity between 20/200 and hand movements and does not adequately discuss extraocular movements.

Every author of a textbook must be forgiven a few errors, although in a volume of this sort they may be rather serious. The omission of the symptom of photophobia in the discussion of congenital glaucoma and the statement that it is technically impossible to reattach a totally detached retina, are examples.

Because the nature of a "synopsis" precludes adequate discussion of underlying physiologic mechanisms, this book is not suitable as a textbook for medical students. It is, of course, not intended as a reference book for the practicing general physician. It will probably be of greatest value to the intern or general practice resident who wishes a brief review of the more practical aspects of ophthalmology during his training. For this, the book may be recommended.—MATTHEW D. DAVIS, M.D.



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AIDS TO ARITHMETIC IN NURSING

A Complete Textbook for the Nurse. Second Edition, by William C. Fream, S.R.N., D.T.A. Cert. (Hous.), S.T.D. (London) Male Tutor, N. Nigeria; formerly Male Tutor, Federal Government of Nigeria and Tutor in Sole Charge, Highwood Hospital for Children, Brentwood Essex. Bailliere, Tindall, and Cox, London. 1959. 200 pages. Price: $2.25.

This book was written primarily for practitioners of nursing in Great Britain and other British territories. Evidence of this is shown by the use of the British system of currency in setting up problems and in references to the British Thermal Unit and the British Pharmacopoeia. The editors in the foreword to the Nurses' Aid Series of which Aids to Arithmetic is a unit, state that these books cover the subjects included in the "syllabus of the General parts of the Register." The author himself refers to the volume as an aid to "State Registered nurses." Both of these statements relate to the British system of Nursing Education which differs from Nursing curricula in the United States.

The book is compact and concise. The early chapters present a review of basic arithmetic with problems for practice. The later chapters deal with the application of basic techniques in arithmetic to some of the problems constantly occurring in the day-to-day ward situations.

Such a volume must be invaluable to British nurses or to any nurses working in Great Britain or other British territories. It would probably be of less use to nurses practicing in the United States. The same material is available in the pharmacology textbooks employed in the basic curricula for nurses in the United States. Nurses contemplating employment in Great Britain or other British territories would profit by owning this book.—SUSAN C. YEOMANS, R.N.M.A.

SYNOPSIS OF GYNECOLOGY

By Robert James Crossen, M.D., Associate Professor of Clinical Gynecology and Obstetrics, Washington University School of Medicine, St. Louis, Mo., Daniel Winston Beacham, M.D., Assistant Professor of Clinical Obstetrics and Gynecology, Tulane University School of Medicine, New Orleans, La., Woodard Davis Beacham, M.D., Professor of Clinical Obstetrics and Gynecology, Tulane University School of Medicine, New Orleans, La. The C. V. Mosby Company, St. Louis. 1959. 340 pages. Price: $6.50.

Synopsis of Gynecology is valuable reading for the physician who requires a general knowledge of gynecology in his practice. This abridged presentation covers the important aspects of the field. The book is conventionally divided into three major areas: (1) the anatomy, endocrinology, and physiology of the pelvic organs, (2) the gynecological examination, and (3) the pathological entities. Strong emphasis has been placed on the first two areas.

Of the sixteen chapters, the outstanding two are "the Gynecologic Examination and Diagnosis" and the "Malignant Diseases of the Uterus." Anyone, specialist or generalist, would profit substantially from reading the chapter on examination and diagnosis. The illustrations and the pictures selected for this section are especially commendable. The excellent chapter on malignant disease of the uterus unfortunately omits a discussion of palliative therapy in recurrent cases. In addition, it presents the acceptable, but technically complicated surgical treatment of invasive carcinoma of the cervix as a commensurate alternative to radiation therapy. Realistically, only a well-trained surgeon frequently doing really extensive radical surgery can achieve the survival results comparable with those treated by irradiation. Furthermore, it is a common error to assume without actual statistical examination that one's results with any method are the equal of those published by others.

Subjects of special interest are included, such as medicolegal points in gynecology, sexual frigidity, premenstrual tension, pessaries, and the psychosomatic aspects of gynecology; these are frequently overlooked by authors. Also there is an abundance of pertinent, well annotated illustrative material throughout the book. For those desiring supplementary knowledge, the bibliographies at the end of each chapter are excellent.

This synopsis has been in circulation for 28 years with five editions and will doubtlessly continue to be one of the better compendiums on gynecology. —C. ROBERT JACKSON, M.D.

THE STORY OF DISSECTION

By Jack Kevorkian, M.D. Philosophical Library, Inc. New York. 1959. 80 pages. Price $3.75.

This is a very brief, hence superficial, resume of the development of attitudes toward human vivisection, dissection, and necropsy, considered by historic periods, from antiquity to the 20th century. The recognition of the importance of necropsy, both for forensic and scientific purposes, is especially emphasized as a force in gaining popular and official sanction for human dissection.—H. W. MOSSMAN, Ph.D.

BIOCHEMISTRY OF HUMAN GENETICS

Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Cecilia M. O'Connor, B.Sc. Little, Brown and Company, Boston. 1959. 347 pages. Price: $9.50.

This volume includes the papers presented and the recorded discussion at a Ciba Symposium entitled "Human Biochemical Genetics in Relation to the Problem of Gene Action" held May 13–16, 1959. The following authors are represented by full papers: Penrose (general human genetics), Kalckar (galactosemia), Kalow (cholinesterase types), Kalmus (sense perception), Childs and Zinkham (primaquine sensitivity), Itano, Singer, Robinson, Hunt,

and Ingram (hemoglobins). In addition there are shorter papers on myoglobins, haptoglobins, transferrins, blood group factors, and gamma globulin variants. The discussants include, besides those already mentioned, Lederberg, Ceppellini, Grubb, Cavalli–Sforza, Eagle, Luria, Smithies, Neel, and many other eminent geneticists and biochemists.

This provides an excellent summary of some of the most exciting aspects of human biochemical genetics as of the time of the Symposium. The discussions following the papers are frequently very enlightening, providing both new information and insight into the current thinking of people in the field. There are a lucid introductory paper by Penrose on general human genetics and a concluding paper by Brenner on DNA-protein relations that are particularly thought-provoking, and a panel discussion on the possibilities of tissue culture genetics. A very useful and interesting book—JAMES F. CROW, Ph. D.

PEDIATRIC PATHOLOGY

By Daniel Stowens, M.D., Pathologist, Children's Hospital Society of Los Angeles; Associate Professor of Pathology, University of Southern California. Williams & Wilkins Co., Baltimore 2. 676 pages. Price: $20.00.

The preface of this book states that it deals primarily with pathology and was written to the greatest degree to be of assistance to the pathologist. While this is true, it has also a great amount of material of interest to the pediatrician as well. It satisfies a need long felt for a book on the pathology of the young years which is not answered by either Potter's or Morison's books—both which are admirable texts of neonatal and fetal pathology. This book covers the area between these books and the standard textbooks of pathology and does it in quite thorough detail. The material is based on a selected series of 10,000 autopsy and surgical cases which the author reviewed during his tenure as Registrar for the American Registry of Pediatric Pathology. The vast majority of children's diseases is adequately covered and there is a well chosen bibliography of current references at the end of each chapter. Occasionally there are peculiar omissions such as with Listeria infections in which 5 references are included in the bibliography, while the subject is brushed aside with three sentences in the text under the heading of Herpes Simplex infection. It is stated that the two give rather similar lesions. However, the book includes discussions of most of the current problems such as Coxsackie viruses, cytomegalic inclusion disease, inborn errors of metabolism, alveolar proteinosis, and renal rickets.

A few criticisms are in order, however. Doctor Stowens states in his preface that many of his ideas (which are interspersed freely throughout the book) are controversial and may bring, "howls of disagreement or scorn." This probably is correct. Oftentimes impressions are included where statistical studies have been carried out and could have been mentioned. In his chapter on erythroblastosis he raises questions on the subject which have been well answered in Allen and Diamond's book. The weight and height charts given in the book are very good as far as they go, but the organ weight charts are not comparable to Potter's (from which they are taken) or especially Farber's book (now out of print). It is a pity these were not included since they are now unavailable. Sudden and Unexpected Death in Infancy, an ever-recurring problem in pathology, is dealt with summarily in three pages based almost entirely on the author's personal opinions. A short bibliography is included however.

Probably the most unfortunate limitation to the book is the virtual absence of gross photographs which makes it of limited use to readers other than pathologists and curtails its teaching use. This is especially apparent in the short chapter on cardiac malformations.

These flaws which have been enumerated, and others like them, become very small when one considers that there is no other textbook such as this available. The profuse number of photomicrographs and the bibliography more than compensate for any of the shortcomings of the book.—BYRON A. MYHRE, M.D.

CARCINOGENESIS MECHANISMS OF ACTION

Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch. and Maeve O'Connor, B.A. Little, Brown & Co., Boston. 336 pages. Price: $9.50.

This book consists of 20 papers and the accompanying discussion presented at a symposium to which attendance was limited to 29 world authorities in experimental carcinogenesis. Although primarily of value to the research specialist, most of the papers are not overly long and may serve to feed the intellectual appetite of the physician. It is of interest to be able to read and compare the many approaches to the cause of cancer, all brought together in one small book. The subjects include the mechanism whereby virus may induce tumors, carcinogenesis in diabetic rats, immunological aspects of cancer, stages in the process of carcinogenesis including the role of irritation, hormonal carcinogenesis, ionizing radiation and leukemogenesis, the role of metals in the carcinogenic process, and problems in testing substances for possible carcinogenicity. Several papers deal with highly specific mechanistic questions. None deal with clinical problems or with tumor formation in man directly.

This is not a book to obtain a summary in digest form of what's new in research on the cause of cancer. Instead it will reveal the baffling complexity of the problem and, in spite of the progress already made, our present state of ignorance. Certainly the physician will find many of the facts and points of view of interest, some of which will be helpful in answering the questions of inquiring patients and friends—R. K. BOUTWELL, Ph.D.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 15th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where department numbers follow advertisements, replies should be addressed in care of The Wisconsin Medical Journal.

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WANTED: ASSOCIATE, either on salary or partnership. Required to do some general practice. California license necessary. Write: John F. Bennett, M.D., F.A.C.S., 585 Dowling Blvd., San Leandro, California. p6–7

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WANTED: MEDICAL DIRECTOR for institution for the retarded. General practice and administrative experience required. Salary $14,160 to $21,060 depending on qualifications. Write: Mr. A. C. Nelson, Superintendent, Northern Colony and Training School, Chippewa Falls, Wisconsin. g11tf

WANTED: MEDICAL DIRECTOR for institution for the retarded. Specialty in pediatrics or internal medicine required. Staff of five physicians plus consultants in all specialties. Salary $18,660 to $21,060 depending on qualifications. Write: Mr. John M. Garsteckl, Superintendent, Southern Colony and Training School, Union Grove, Wisconsin. g11tf

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WANTED: A locum tenens for June, July and August with the possibility of permanent position. Excellent opportunity for man just out of training. Western Wisconsin, population 2,400, 22-bed hospital in town. Large active practice. Contact Dept. 908 in care of the Journal. m4–5

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WANTED: GENERAL PRACTITIONER. Mideastern Wisconsin general practitioner desires associate, preferably a man with an interest in surgery. One year salary, then profit percentage leading to an equal partnership. Contact Dept. 887 in care of the Journal. m5–12

WANTED: Young general practitioner interested in obstetrics and pediatrics to join small group in central Wisconsin city of 20,000. Salary, leading to partnership. Contact Dept. 914 in care of the Journal. m5–6

WANTED: General practitioner needed to serve village of Spring Green, 1,100 population, and surrounding area within radius of 12 miles, located in southwestern Wisconsin, 40 miles west of Madison. A community-Lions Club sponsored clinic designed by Frank Lloyd Wright has just been completed and is ready for occupancy. Reasonable rent. Contact Felix Matarrese or Ken Hottmann, Spring Green, Wisconsin. 5–7

GENERAL PRACTICE ASSOCIATE wanted by a partnership consisting of two men, one doing general medicine and allergy, the other, general surgery. Southeast Wisconsin industrial city, 60,000 population. Excellent opportunity for advancement to partnership. Contact Dept. 919 in care of the Journal. m6–7

FOR SALE: Private practice in internal medicine, sharing facilities with two other internists. Thriving practice. Available July 1. Terms can be arranged. Contact Dept. 922 in care of the Journal. m 6–7

the Wisconsin Medical Journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

VOL. 60, NO. 7—JULY 1961

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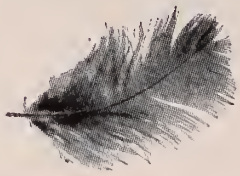

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COUNTY SOCIETY PROCEEDINGS

ASHLAND–BAYFIELD–IRON

Dr. John Rankin, associate professor of internal medicine at the University of Wisconsin Medical School, Madison, addressed the Ashland–Bayfield–Iron County Medical Society in May. He explained the work of the pulmonary function laboratory at the University Hospitals in Madison and talked on recent developments in cardio-respiratory disease. His talk was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society.

BARRON–SAWYER–BURNETT

Members of the Barron–Sawyer–Burnett County Medical Society heard *Dr. George G. Griese*, Marshfield, talk on "Reducing the Newborn Mortality Rate" at their April 12 meeting in Cumberland. Doctor Griese's appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society.

At their May 10 meeting in Rice Lake, the society members heard a symposium on chest diseases. *Dr. C. J. Strang*, Barron, reported on the proceedings at the annual meeting of the State Medical Society. Eighteen members were present at the meeting.

BROWN

Members of the Brown County Medical Society heard a report from their delegates to the State Medical Society annual meeting at their May 11 session in Green Bay. The society's annual golf day was held May 23.

CHIPPEWA

Twenty-two members of the Chippewa County Medical Society heard *Dr. George E. Collentine, Jr.*, Milwaukee, talk on "Cardiac Arrest" at their April meeting in Chippewa Falls. Other speakers at the meeting were *Dr. W. D. Stovall* and Mr. R. R. Vevle, both of Madison. During the business session the society discussed a proposed meeting with the County Welfare Department.

At the May 16 meeting, held at the Elks Country Club in Chippewa Falls, 20 members heard *Dr. Donald R. Griffith*, Eau Claire, talk on Addison's Disease. During the business session the group discussed relations with the county welfare department and the new State Medical Society regulations.

The next meeting will be held on September 5 and will feature surgery.

DANE

A report and discussion of the proceedings at the annual meeting of the State Medical Society were the main features of the May meeting of the Dane County Medical Society.

The society also issued a public statement, recommending that, unless specifically requested by an attending physician, all ambulances and other vehicles carrying the sick and injured be required by the usual law enforcement procedures to observe all traffic rules and regulations. The letter of recommendation was forwarded to the mayor of Madison, city and county law officers, ambulance companies, and similar agencies in surrounding counties.

DOOR–KEWAUNEE

Dr. Herbert Sandmire, Green Bay, discussed "The Incompetent Cervix as a Cause of Mid-Trimester Miscarriage" at the March 28 meeting of the Door–Kewaunee County Medical Society. During the business session, the members heard a discussion of WIAA fees and a report of the annual Presidents and Secretaries Conference held in Madison.

JEFFERSON

"Management of the Acutely Ill Asthmatic Patient" was the topic of *Dr. J. R. Talbot*, Madison, in a talk before the Jefferson County Medical Society on April 20. During the business session the society voted that members who had either 50 years service or were retired should be made associate members. *Dr. R. R. Liebenow*, Lake Mills, reported on the delegates caucus held in Oconomowoc and on the annual Presidents and Secretaries Conference held in Madison.

LA CROSSE

Sixty-one members of the La Crosse County Medical Society heard *Dr. Gordon Davenport, Jr.*, Madison, present a paper on "Treatment of Facial Injuries" at a meeting April 17 in La Crosse. The meeting was held in conjunction with the Seventh Councilor District.

In a business session the society established a Pharmacy Liaison Committee, discussed the American Cancer Society television program, and discussed the resolutions being presented to the House of Delegates at the annual meeting.

At their May meeting the members heard *Dr. M. J. Javid*, Madison, talk on "Recent Advances in Neurosurgery or Other Neurosurgical Topics." His appearance was sponsored by the Charitable, Educational and Scientific Foundation.

MANITOWOC

New officers of the Manitowoc County Medical Society for the next year are: president—*Dr. R. G. Yost*, vice-president—*Dr. C. E. Wall*, secretary-treasurer—*Dr. R. G. Strong*, delegate—*Dr. T. H. Rees*, alternate—*Dr. W. F. Smejkal*, all of Manitowoc.

Physicians whose names appear in italic are members of the Society.

ONEIDA–VILAS

"Surgery of the Hand" was the topic of *Dr. Gordon Davenport, Jr.*, Madison, when he spoke before the Oneida–Vilas County Medical Society April 19 at Rhinelander. Twenty-two members were present. *Dr. W. K. Simmons* and *Dr. Allen Johnson*, both of Rhinelander, reported on the annual Presidents and Secretaries Conference held in Madison.

OUTAGAMIE

Dr. Benjamin Gasul, Chicago, spoke on heart ailments in children at the April 20 meeting of the Outagamie County Medical Society in Appleton. Doctor Gasul is professor of pediatrics at the University of Illinois Medical School.

OZAUKEE

Dr. R. H. Cassidy, Milwaukee, talked on "Fractures In Children" at the April 27 meeting of the Ozaukee County Medical Society held in Grafton. His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society.

PIERCE–ST. CROIX

Dr. John Falls of the Interstate Clinic, Red Wing, Minnesota, was guest of honor at the March meeting of the Pierce–St. Croix County Medical Society. The meeting was held at the home of *Dr. F. B. Klaas* in East Ellsworth.

RACINE

Group insurance plans for the income protection of employees disabled by off-the-job illness and accidents were discussed before the April meeting of the Racine County Medical Society. Dr. Robert W. Butler, medical director of Scovill Manufacturing Co. of Waterbury, Connecticut, was the speaker.

RICHLAND

Dr. A. B. Weinstein, associate professor of medicine at the University of Wisconsin Medical School, Madison, spoke before the May meeting of the Richland County Medical Society, held in Richland Center. His topic was use of the artificial kidney. Ten members attended the meeting.

SHEBOYGAN

The Sheboygan County Medical Society on May 25 held a joint meeting with the Sheboygan County Bar Association at Rocky Knoll Sanitorium. A film was shown on "Traumatic Neurosis." Seventy-five physicians and attorneys attended.

WASHINGTON

Thirteen members of the Washington County Medical Society heard *Dr. F. J. Stoddard*, Milwaukee, discuss "Infertility" at their April meeting held in Menomonee Falls. Doctor Stoddard, associate clinical professor of obstetrics and gynecology at Marquette University School of Medicine, appeared under the sponsorship of the Charitable, Educational and Scientific Foundation of the State Medical Society.

WINNEBAGO

The April dinner meeting of the Winnebago County Medical Society, in conjunction with the Winnebago County Dental Society, was held April 11 at Holiday Inn near Appleton. Guest speaker was Dr. Walter W. Dalitsch, Chicago, who spoke on "Cases of Common Interest for Physicians and Dentists."

In May the Society held a dance at the Oshkosh Country Club as a benefit event for the American Medical Education Foundation.

WOOD

Dr. Robert M. Heywood, Marshfield, was speaker at the April 27 meeting of the Wood County Medical Society held in Wisconsin Rapids. His topic was "Drug Reactions." Twenty-six members attended.

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NEWS OF WISCONSIN PHYSICIANS

Two Rivers Rotary Club Hears Doctor Fodden

"Is Medicine An Art or a Science?" was the subject of a talk by Dr. John H. Fodden, Manitowoc, before the Two Rivers Rotary Club in March. Doctor Fodden, a pathologist, outlined the duties of his specialty.

Doctor Bartos Talks on Physical Fitness

The Waukesha Women's Club heard *Dr. Joseph A. Bartos*, Waukesha, talk on physical fitness at their March meeting. Doctor Bartos pointed to the lack of exercise Americans get in their daily living and urged the members of the club to do more walking as a form of exercise.

Dr. Weisse a Fellow in Surgeons Group

Dr. Harris A. Weisse, a partner in the Plymouth Clinic, was formally inducted into the International College of Surgeons as a Fellow in general surgery at the convocation exercises held May 18 at the Civic Opera House, Chicago, Ill.

Neurologist Addresses Superior Group

Dr. Francis M. Forster, chairman of the Department of Neurology at the University of Wisconsin Medical School, Madison, addressed the teachers of the Superior school system April 5. He talked on neurologic problems in children, including cerebral palsy, epilepsy and mental retardation.

Doctor Kaufmann Practices in Denmark

Dr. John H. Kaufmann has been associated with *Dr. G. V. Hering* in the Denmark Clinic since March. Doctor Kaufmann is a University of Wisconsin Medical School graduate. He has been a flight surgeon with the U. S. Air Force in Newfoundland and Florida for the past two years.

Hospital Staff Honors Doctor Strauch

Dr. C. B. Strauch, Hazel Green, was honored by the Hazel Green hospital staff May 8 in recognition of 21 years of service to the community. He was presented with a new physician's bag and a recording made by past and present employees at the hospital, recalling incidents in the past 21 years.

Cancer Group Hears Doctor Wochos

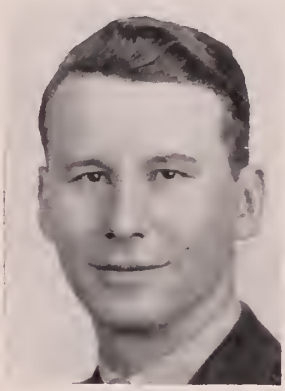
Dr. Robert G. Wochos, Green Bay, addressed the members of the Kewaunee County Unit of the Wisconsin Division, American Cancer Society, at their annual meeting in May.

Physicians whose names appear in italic are members of the Society.

Doctor Balder Practices in Elroy

Dr. Roy Balder, Hillsboro, has announced plans to practice full-time in Elroy. He formerly maintained part-time hours there while practicing in Hillsboro.

Doctor Frackelton Heads Plastic Surgeons



W. H. Frackelton, M. D.

Dr. William H. Frackelton, Milwaukee, was elected president of the American Association of Plastic Surgeons at the group's annual meeting in New York City in May. The doctor is head of the department of plastic surgery at Marquette University School of Medicine and former president of the American Society for Surgery of the Hand.

Milwaukee Physicians Receive Grants

Three Milwaukee physicians have been named recipients of scholarships, financed by United Cerebral Palsy, to study neuro-muscular diseases at the Cook County Postgraduate School of Medicine in Chicago. They are Doctors *George R. Wagner*, *James F. McDermott* and T. E. Kendall. Doctor Wagner is a member of the staff of the Bureau of Maternal and Child Health, Milwaukee Health Department, and Doctors McDermott and Kendall are residents in physical medicine at the Veterans Administration Hospital in Wood.

Hold Television Discussion on Hospitals

Dr. James M. Sullivan, president of The Medical Society of Milwaukee County, appeared on a panel discussion entitled "Hospital Report" over television station WTMJ–TV in May. Also on the panel were David S. Neugent, president of the advisory board of Trinity Hospital and Stanley W. Martin, administrator of Milwaukee Hospital. The panel answered questions from the viewing audience ranging from treatment of drug addicts to why hospital food is cold.

Dr. Sorenson Addresses Janesville Rotarians

"Aging is inevitable, but we are doing something about it," *Dr. E. D. Sorenson*, Elkhorn, then president of the State Medical Society, told Janesville Rotarians at their April meeting. Doctor Sorenson discussed the problems of aging, preparation for retirement, and the Kerr–Mills bill as a method for financing medical care.

Doctor Dunn Practices Sixty Years

Sixty years of medical practice were completed May 5 by Dr. J. F. Dunn, Whitewater, who tried "unsuccessfully" to retire several years ago. The unsuccessful part stems from the fact that even though he closed his office, patients continue to call at his home daily. Doctor Dunn graduated from medical school in 1901, returned to his native Whitewater, and has practiced there ever since.

Safety Council Hears Talk by Dr. Samp

"Hadacol, Honegar and Hooey" was the topic of *Dr. Robert Samp*, Madison, when he addressed the Twin City Safety Council in Menasha April 13. Some 250 people attended.

Doctor Adams Practices in Brandon

Dr. Harold Adams, Tomahawk, has announced plans to establish his practice in Brandon. Construction of a clinic in the community is planned by the physician.

Jackson Clinic and Foundation Hold Postgraduate Meeting

Fifty-two physicians from Madison and surrounding area attended the spring postgraduate meeting of the Jackson Clinic and Foundation held in April. Guest speaker was Dr. Frank Winston, Madison psychiatrist. Speakers from the clinic were: Drs. *Arnold Jackson*, Barbara Brew, *Theodore Hartridge, Oscar Foseid, Vaughn Demergian, Robert Straughn, John Morledge, William Parsons, Jr., Hubert Ashman, Luther Holmgren, Howard Mahaffey* and *David Williams*.

Doctor Bachhuber Talks to Woman's Club

"Hypnosis In Medicine" was discussed by *Dr. F. G. Bachhuber*, Mayville, at the April meeting of the Dodge County Federation of Women's Clubs. He explained the principles and outlined the possibilities of cure under medical supervision.

Doctor Hammer River Falls Health Officer

Dr. Roland Hammer was named city health officer by the River Falls Council in April.

Doctors Answer Questions on Cancer

A panel discussion on questions frequently asked about cancer was presented April 22 by a panel of five physicians over television station WFRV–TV in Green Bay. Participating were *Drs. John E. Dettman, Thomas J. Beno, John Mokrohisky, Frederic Jansen* and *Robert G. Wochos*. All are board members of the Brown County unit of the American Cancer Society.

Doctor Waisman Speaks on Mental Retardation

Dr. Harry Waisman, pediatrician and biochemist at the University of Wisconsin Medical School, Madison, spoke on "Modern Medical Research in Mental Retardation" at the May 13 banquet of the Wisconsin Council for Retarded Children held in Madison.

Kiwanians Hear Doctor Houghton

"Medical Care for the Aged" was the topic of *Dr. John Houghton* of Wisconsin Dells when he addressed the Baraboo Kiwanis Club at their April meeting. Doctor Houghton discussed the care of the aged under the Kerr–Mills Act and proposed Federal legislation, pointing out the differences in the two philosophies.

Douglas County Society Honors Doctor Sincock

H. A. Sincock, M.D.

Dr. H. A. Sincock, Superior, received a plaque from the Douglas County Medical Society and Auxiliary in May in recognition of his 50th anniversary in practice. *Dr. J. W. McGill* presented a narrative on some of Doctor Sincock's early experiences. *Dr. V. E. Ekblad*, Superior, made the presentation.

Doctor Koogler Joins Hustisford Practice

Dr. James Koogler became associated with Dr. H. G. Withrow in Hustisford in April. He comes to the Wisconsin community from Battle Creek, Michigan. His father, Dr. Paul Koogler formerly practiced in the community and established the hospital there.

Doctor Veit Addresses Registered Nurses

Dr. Henry Veit, Milwaukee, talked on "Psychosomatics" at the April meeting of the Ozaukee County Registered Nurses.

Physicians Named to Neenah Health Committee

Dr. John Canavan and *Dr. George Hildebrand* have been named as members of a five-man advisory committee to assist the Neenah city health department. The committee will advise and support the city health program and promote general understanding of its aims.

Doctor Hoegemeier Joins Clinic Staff

Dr. H. W. Hoegemeier, a specialist in internal medicine, has joined the staff of the West Side Clinic in Green Bay. A graduate of Indiana University

School of Medicine, he interned at Indianapolis General Hospital and received his specialty training at the Veterans Administration Hospital in Chicago. A veteran of naval service, he practiced in Freeport, Ill., prior to moving to Green Bay.

Doctor Crandall Leaves Richland Center

Dr. George Crandall has announced that he will leave Richland Center and join the Redondo Beach Medical Clinic in California. He has been with the Pippin Clinic in Richland Center for the past five years, and prior to that time was at the Marshfield Clinic.

Doctor Lanier Talks to College Club

Dr. Patricia F. Lanier, Kewaunee, discussed "Aging With a Future—Everyone's Right and Concern" before the Kenosha College Club at their April meeting. Using the White House Conference on Aging as a background, she discussed the problems of the aged.

Physician Panel at Eau Claire Rotary Meeting

Five physicians served on a panel at the April meeting of the Eau Claire Rotary Club, answering questions submitted by members of the club. Participating were *Drs. John Lowe, Don Willison, S. L. Henke, Paul Spelbring* and *Albert Lorenz.*

Doctor Peterson Opens Kenosha Practice

Dr. Clifton E. Peterson is now associated with *Dr. Chester A. Sattler* in the practice of orthopedic surgery and fractures in Kenosha. The physician recently completed specialty training at the Mayo Clinic in Rochester, Minn. A graduate of University of Rochester School of Medicine in New York, he interned at University of Minnesota Hospitals in Minneapolis and received residency training there prior to going to the Mayo Clinic.

MacCornack Day at Whitehall

Hundreds of friends, patients and colleagues gathered in Whitehall June 11 to honor *Dr.* and Mrs. *R. L. MacCornack.* MacCornack Day was sponsored by the Hutchins–Stendahl Post 191 of the American Legion. A band concert preceded the program; *Dr. N. S. Simons* acted as master of ceremonies.

Tributes to Doctor and Mrs. MacCornack were made by G. E. Sipple, Menomonie, past department commander of the American Legion; B. W. Ingli, La Crosse, of the Gateway Area Council, Boy Scouts of America; and for the medical profession, *Dr. W. D. Stovall*, Madison, of the University of Wisconsin Medical Center, and *Dr. Carl N. Neupert*, Madison, State Health Officer. Presentation of the honorary scroll was made by the Rev. O. G. Birkeland, Whitehall.

Harold Arnesan Photo

Dr. and Mrs. R. L. MacCornack

Doctor Mac, as he is affectionately called by Whitehall residents, has been semi-retired from his active practice since 1956; but he has continued as health officer for the city of Whitehall, an office he has held since 1923.

He is a member of the Tri-County Medical Society, for which he was secretary 12 years. He also is a member of the State Medical Society and the American Medical Association. In the State Society he was Speaker of the House of Delegates for two years, president of the Seventh Councilor District for two years, and secretary of the La Crosse District organization for two years. In 1954, Doctor MacCornack represented the American Medical Association as the only delegate to the meeting of the British Medical Society in London, England.

Doctor MacCornack, his brother the late Dr. E. A. MacCornack, and Dr. N. S. Simons organized the MacCornack Clinic in Whitehall. Doctor Mac served as president of the clinic from 1923 until 1958. He was also president of the Whitehall Community Hospital from 1926 until his retirement in 1959.

Doctor MacCornack wrote the point system for scoring junior high school boys who are sent to Badger Boys State. This system was adopted by the American Legion's Department of Wisconsin. He is a past commander of Hutchins–Stendahl Post. He served as a medical officer during World War I.

Doctor Mac has been active in church, civic, and voluntary organizations as well as the Boy Scouts and other sports activities. He helped organize the bloodmobile program in the county. He is known as the father of golf in Whitehall, having started the Whitehall golf course in 1924 with Dr. N. S. Simons and the late S. N. Hegge.

Mrs. MacCornack has been just as active. She is a charter member of both the Music Study and Women's Study clubs and she was instrumental in organizing the Girl Scout troop in Whitehall. She is an active member of the American Legion Auxiliary, has been active in church work, ladies groups and the hospital auxiliary.

The MacCornacks have three children, Dr. R. L. MacCornack, Jr., South St. Paul, Minn.; Irene, Mrs. A. Lamprecht, Edmonton, Alberta, Canada; and Mary, Mrs. Robert Forsythe, Edina, Minn. The children, along with their families, were honored guests at the occasion.

Dr. Leonard Honored by Mexican School

Dr. T. A. Leonard, Middleton, has been granted a degree as honorary visiting professor of the University of Vera Cruz Medical School, Vera Cruz, Mexico. The degree was awarded by University president Dr. Aguierre Gonzalo Beltran in "profound appreciation for invaluable and unselfish services" in the development of the medical school.

T. A. Leonard, M. D.

Ten years ago Doctor Leonard became interested in the problems of the medical school while on vacation in the Vera Cruz area. The school, along with a 500-bed hospital, was just being established. In cooperation with the University of Wisconsin Medical School, where he is a clinical instructor in obstetrics and gynecology, Doctor Leonard provided advice on textbooks, course content and instruction in all phases of the new medical school. He helped the Mexican school establish studies in cancer cytology and arranged for students to take special cancer studies at the University of Wisconsin. He was largely responsible for interesting the Vera Cruz school in developing a pilot plan of cancer detection centers in that state, which may become a pattern for all of Mexico.

Physicians Talk on Arthritis in Madison

Three University of Wisconsin Medical School faculty members participated in a public forum on arthritis at the Wisconsin Center in Madison in May. They are *Dr. D. Murray Angevine*, Dr. Arthur A. Siebens, and *Dr. John H. Flinn*. A short film, "Quackery and Arthritis," was shown following the discussion.

Homemakers Hear Talk by Doctor Gerol

Chiropractors, patent medicine and cure-all machines were the target of *Dr. A. Yale Gerol*, Racine, when he addressed 400 members of the state organization of homemakers' clubs in Wausau in May.

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MEDICAL MEETINGS—POSTGRADUATE COURSES

Wisconsin Academy of General Practice

The 13th Annual Scientific Assembly of the Wisconsin Academy of General Practice will be held September 18 and 19 at the Milwaukee Auditorium. Twelve hours of Category I credit are available for all Academy members. All physicians, whether Academy members or not, are invited to attend. There is no registration fee.

Subject matter includes: Basic Principles of Respiratory Physiology; Chronic Chest Disease of Children; Results and Comments of the Maternal Mortality Study; Blood Fractions in Clinical Medicine; Practical Endocrinology; Opportunities for GP's to detect Cancer of the Colon and Rectum; Hypnosis in Obstetrics; and Behavior Problems in Children.

Distinguished lecturers on the program include Forrest Bird, M.D., of Palm Springs; Alex J. Steigman, M.D., of Louisville, Kentucky; Emerson Day, M.D., of New York; Edgar End, M.D., John R. Evrard, M.D., Wm. W. Engstrom, M.D., and Robert Purtell, M.D., of Milwaukee among others.

On Sunday, September 17, the Wisconsin Academy of General Practice Congress of Delegates will convene at 7 p.m. at the Schroeder Hotel in Milwaukee.

For reservations or further information, contact: Mr. Robert H. Herzog, Executive Secretary, Wisconsin Academy of General Practice, 2040 W. Wisconsin Avenue, Room 305, Milwaukee, Wisconsin.

Tours Available to WMA Assembly

Varig Airlines has announced that a choice of three "Special Medical Study Tours" is available to members attending the World Medical Association's Fifteenth General Assembly, being held in Rio de Janeiro, September 15 through September 20.

Tour folders and other pertinent information can be obtained by contacting Tour Manager, Varig Airlines, 630 Third Avenue, New York, New York.

Society for Crippled Children and Adults

The 1961 annual convention of the National Society for Crippled Children and Adults will be held November 17–21 at the Denver–Hilton Hotel, Denver, Colorado.

Colorado Pediatric Course

A postgraduate course on Clinical and Research Advances in Pediatrics and Child Guidance will be held August 21–25 at the Stanley Hotel in Estes Park, Colo. The course is being presented by the University of Colorado School of Medicine, Department of Pediatrics, and the Office of Postgraduate Medical Education. For further information write to the University, 4200 East Ninth Avenue, Denver 20, Colorado.

WISCONSIN CALENDAR COMING EVENTS

1961

July 28–29: SMS Council meeting, Land O' Lakes.

Aug. 29–31: UW Postgraduate course, Psychiatric symposium, Dr. R. Roessler, chrm., Wisconsin Center Building, Madison.

Sept. 13: Special Conference on Problems of the Newborn, St. Mary's Hospital, Wausau.

Sept. 18–19: Annual meeting, Wisconsin Academy of General Practice, Milwaukee.

Sept. 28–30: UW postgraduate course, Anesthesiology, Dr. O. S. Orth, chrm., University Hospitals, Madison.

Oct. 13–14: UW postgraduate course, Psychiatry, Dr. R. Roessler, chrm., Wisconsin Center Building, Madison.

Oct. 19–20: Milwaukee Medical Conference, Milwaukee County Hospital.

Oct. 23–24: Scientific session, American Cancer Society, New York City.

Nov. 13–17: Annual meeting, American Public Health Association, Detroit, Mich.

Nov. 16–18: UW postgraduate course, Rehabilitation of Patients with Injuries of the Spinal Cord, Dr. A. Siebens, chrm., Wisconsin Center Building, Madison.

Nov. 28–Dec. 1: AMA Clinical Meeting, Denver, Colorado.

1962

Apr. 5–7: UW postgraduate course, Genetics in Pediatrics, Drs. J. Crow and N. Smith, co-chrm., Wisconsin Center Building, Madison.

Apr. 26–28: UW postgraduate course, Psychosomatic Medicine, Dr. David Graham, chrm., Wisconsin Center Building, Madison.

May 8–10: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 10–11: UW postgraduate course, Orthopedic Surgery, Dr. H. Wirka, chrm., Wisconsin Center Building, Madison.

May 17–19: UW postgraduate course, Anatomy, Physiology and Pathology of the Holocrine, Apocrine and Eccrine Glands, Dr. S. Johnson, chrm., Wisconsin Center Building, Madison.

June 11–15: AMA Annual Meeting, Chicago, Illinois.

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California.

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Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

VOL. 60, NO. 8—AUGUST 1961

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COUNTY SOCIETY PROCEEDINGS

DANE

The Dane County Medical Society Foundation recently approved the first research award from the James & Clara Joss Foundation (within the structure of the Research Foundation) to *Matthew D. Davis, M.D.*, and Ronald L. Engerman, Ph.D., for a project entitled "Experimentally Induced Retinopathy in Animals, Ophthalmoscopic and Histologic Correlation." The award is for $1,320, with provision for an additional $660, which includes an additional 10 per cent for indirect costs. Under this program funds are available up to $2,000 per annum. Closing date for applications is March 1 of each year.

New members of the DCMS are *Dr. William H. Nicolaus*, an anesthesiology resident at the University Hospitals who transferred from the Winnebago County Medical Society. Doctor Nicolaus graduated from the UW Medical School in 1957 and was previously located in Neenah and Menasha; and Dr. John D. Maloney, a resident in surgery at Madison General Hospital who received his medical degree from the University of Toronto, Canada in 1959. *Dr. Frederick A. Melms, Jr.*, is a new military member. He is now on active service in Germany. He attended medical school at the Universities of Michigan and Wisconsin, graduating in 1959, and served one year's internship at the Rockford Memorial Hospital, Illinois, before entering military service in July, 1960.

Colonel Paul A. Campbell, chief flight surgeon of the U. S. Air Force, presented a lecture entitled "Man in Space—Medical Aspects" at the June 13 meeting held at the Officers Club, Truax Air Force Base. Colonel Campbell is presently Chief of the Advanced Studies Group at the Aerospace Medical Center, Brooks Air Force Base, Texas.

Physicians whose names appear in italic are members of the Society.

The next regular meeting will be held in September when the annual golf tournament will take place at the Blackhawk Country Club September 12.

DODGE

At the May meeting of the Beaver Dam Medical Forum, *Dr. Norman H. Schulz*, Horicon, spoke on the topic "Hypercalcemia and Hypocalcemia." He presented an outline classifying diseases which are associated with disordered calcium homeostasis according to the pathophysiologic mechanism responsible for the development of hypercalcemia and hypocalcemia.

Special emphasis was placed on the recent increase in diagnosis of hyperparathyroidism in peptic ulcer patients, and it was suggested that ulcer patients be screened with serum calcium levels to rule out parathyroid disease. Doctor Schulz also emphasized the frequency of hypercalcemia in patients with both primary and metastatic malignancies. He suggested that these patients also be checked periodically with serum calcium determinations.

RICHLAND

The June meeting of the Richland County Medical Society was held at the Orion Hill Chalet, *Dr. W. C. Edwards'* summer home on the Wisconsin River. *Dr. Thomas V. Geppert*, senior pediatrician at the Dean Clinic, Madison, gave an interesting and instructive talk on pediatric problems with special emphasis on the blood of the newborn. The dinner, cooked by Doctor Edwards, had roast moose as the main course, a product of last fall's hunting trip in Ontario, Canada.

SPECIALTY SOCIETY PROCEEDINGS

SMS Section on Pediatrics

Dr. Ewald Pawsat, Fond du Lac, was elected chairman of the State Medical Society's Section on Pediatrics during a session at the SMS annual meeting May 2–4. *Dr. Lloyd Williams*, Appleton, was named state chairman for the American Academy of Pediatrics. The Section on Pediatrics, which had one of its most interesting and attentive programs at the annual meeting, has already begun plans for next year's program.

Physicians whose names appear in italic are members of the State Medical Society.

Wisconsin Academy of General Practice

The 13th Annual Scientific Assembly of the Wisconsin Academy of General Practice will be held September 18 and 19 at the Milwaukee Auditorium. Twelve hours of Category I credit are available for all Academy members. All physicians, whether Academy members or not, are invited to attend. There is no registration fee.

For reservations or further information, contact: Mr. Robert H. Herzog, Executive Secretary, Wisconsin Academy of General Practice, 2040 W. Wisconsin Avenue, Room 305, Milwaukee, Wisconsin.

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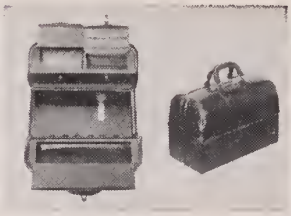

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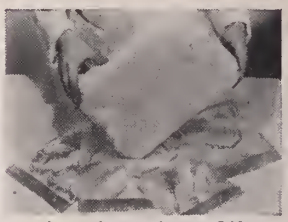

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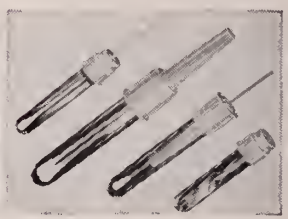

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NEWS OF WISCONSIN PHYSICIANS

Diplomates in Anesthesiology

Seven Wisconsin physicians were certified as Diplomates of the American Board of Anesthesiology as of April 22, 1961. They are: *Dr. Reinaldo S. Barreto*, Madison; *Dr. Frederick D. Cook*, Green Bay; *Dr. Martin J. Denio, Jr.*, Elm Grove; *Dr. J. C. Devine*, *Dr. Kuang S. Kim*, and *Dr. Thomas F. McCormick*, Milwaukee; and *Dr. Donald P. Pederson*, Marshfield.

Dr. Bach Trophy Winner with Trout

Dr. M. J. Bach and his trophy trout.

Dr. Mark J. Bach, Milwaukee, is shown in the picture here holding his 5 pound 9 ounce trout which he caught recently at the Silver Moon Springs Trout Club near Plymouth. The rainbow trout was caught with a nymph, on a flyrod. Although, there are rainbow trout as large as 10 pounds in the pools, this is the largest one caught at Silver Moon Springs this season. By catching a trout over 5 pounds, Doctor Bach becomes a charter member of the Trophy Trout Club.

Joins Edwards Clinic in Richland Center

Dr. Richard W. Edwards joined the Edwards Clinic in Richland Center on July 1. He graduated from the University of Wisconsin Medical School in 1960; he also received his Bachelor's Degree at Wisconsin. For the past year he has been an intern at the St. Vincent's Hospital in Toledo, Ohio. Before entering medical school he served in the hospital corps of the U.S. Navy, spending a year in the U.S. Naval Hospital in Bethesda, Maryland, and two years as a medical officer on the Destroyer USS Gyatt. He is married and has three children.

Marquette University Clinical Day

Participation in the 14th annual clinical day held at the Veterans Administration Center, Wood, under auspices of the Dean's Committee of Marquette University School of Medicine included the following:

Welcome address: Mr. D. C. Firmin, manager, VAC. Introductory remarks: Dr. Francis G. Dickey, Director, professional services, VAC, and *Dr. John S. Hirschboeck*, Dean, Marquette University School of Medicine.

Pheochromocytoma, an Elusive Diagnostic Problem: Dr. Francis G. Scherman, Medicine. An Investigation of the Biological Properties of Sputum: *Dr. Samuel R. Hirsch*, Medicine. Anorganic Heterogenous Bone Implant in Bone Defects in Humans: Richard E. Carey, D.D.S., Oral Surgery. Speech Following Laryngectomy; a Cinefluoroscopic Study: *Dr. Thomas W. Grossman*, Otolaryngology. Clinical Use of Marlex Mesh in Repair of Diaphragm and Abdominal Wall: *Dr. George F. Flynn*, General Surgery.

Bronchial Adenoma: *Dr. Bruce F. Stengel*, Thoracic, C.V. Surgery. Experimental Prevention of Postoperative Ileus by Panthothenic Acid: *Dr. Michael A. Polacek*, General Surgery. Identification of the Bundle of His by Radio-Frequency Conductimetry: Dr. William A. Bormes, Thoracic, C.V. Surgery. An Evaluation of Tissue Changes in the Healing Wound: Dr. Wilbert Wiviott, General Surgery. Suprachoroidal Implantation of Silicone Rubber in Dog Eyes: Dr. L. W. O'Dell, Ophthalmology.

Dr. Francis G. Dickey presented the Staff Award for the best scientific paper to Dr. William A. Bormes. This was a presentation on an electronic device to prevent damage to a vital nerve center in the heart during open heart operations.

An exhibit on Localization of Vascular Lesions of the Brain was presented by the Physical Medicine and Rehabilitation Service.

Doctor Bardenwerper Receives Appointment

H. W. Bardenwerper, M. D.

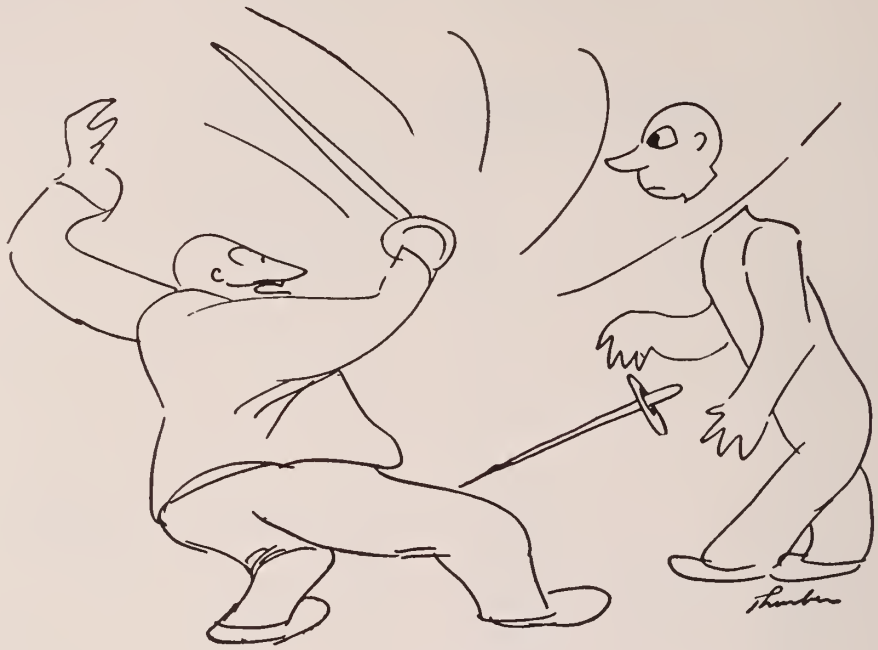
Dr. Hulburt W. Bardenwerper, Waterford, has been appointed an officer of the Northwestern Mutual Life Insurance Co., Milwaukee, with the title of assistant medical director, effective June 15. For the past eight years, Doctor Bardenwerper has been a general practitioner in Waterford and a staff member of the Memorial Hospital, Burlington.

Dr. A. J. Quick Honored

Dr. Armand J. Quick, professor and chairman of the biochemistry department at Marquette University School of Medicine, Milwaukee, was named recipient of the John Phillips Memorial Award for outstanding and distinguished contributions to the field of internal medicine.

The award was given at the annual convocation of the American College of Physicians held at Bal Harbour, Fla., this spring.

Physicians whose names appear in italic are members of the State Medical Society.



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Doctor Quick has gained world wide recognition for the development of the Quick Prothrombin Time test for clotting and determination of liver function and also for the prothrombin-consumption test for obscure bleeding problems. He also is world recognized for his studies in blood diseases and coagulation.

The Marquette faculty member has done extensive work in hemophilia and his clinical contributions with hemophiliac patients has provided these people with a prolonged life span and made them safer for surgery.

Joins Jackson Clinic

Dr. Thomas D. Ghrist has joined the staff of the Jackson Clinic in the department of internal medicine.

A native of Iowa, Doctor Ghrist graduated from the State University of Iowa College of Medicine. He served his internship at St. Louis City Hospital and a residency in internal medicine at Presbyterian–St. Luke's Hospital in Chicago. Doctor Ghrist served in the army for two years.

T. D. GHRIST, M. D.

Previous to joining the Jackson Clinic, Doctor Ghrist served a two-year residency in internal medicine at Ohio State University Health Center, Columbus, Ohio, specializing in hematology. While there, he was an instructor in internal medicine at Ohio State University Medical School.

Doctor and Mrs. Ghrist and their three children are residing at 657 Odell Street in Madison.

Dr. Garner Participant in AMA Meet

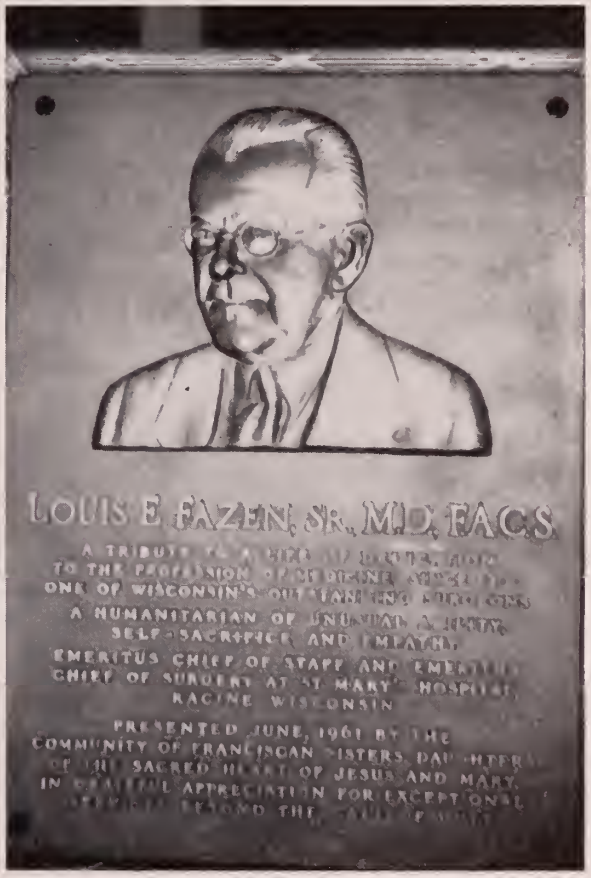
Dr. Lawrence L. Garner, Milwaukee, and Dr. Elmer J. Ballintine, Cleveland, were co-authors of a paper presented before the Section on Ophthalmology of the American Medical Association at the New York City meeting June 29. The title was "Improvement of the Co-Efficient of Outflow in Glaucomatous Eyes During Prolonged Local Treatment with *L*-Epinephrine." This was the first of three papers presented during a Symposium on Epinephrine Therapy of Glaucoma.

Milwaukeeans Exhibit at AMA Meeting

Dr. Lawrence L. Garner, director of the Glaucoma Referral Center at the Marquette University School of Medicine, Milwaukee, in collaboration with *Dr. E. Franklin Carl* and Dr. James Ferwerda, both of Milwaukee, presented an exhibit at the Section on Ophthalmology of the American Medical Association meeting held June 25–30 at the Coliseum in New York City. Title of the scientific exhibit was "Acetazolamide (Sustained Release) in Glaucoma; Comparison with Conventional Carbonic Anhydrase Inhibitors." The three physicians represented Marquette University School of Medicine, County General Hospital, and the Veterans Administration Regional Office, Milwaukee.

Doctor Fazen, Sr., Honored

Dr. Louis E. Fazen, Sr., Racine, was honored on June 14 by St. Mary's Hospital for exceptional service covering a period of 61 years of active practice. During the testimonial dinner, a bronze plaque was presented Doctor Fazen. The inscription reads: "A tribute to a life of dedication to the profession of medicine; since 1900 one of Wisconsin's outstanding surgeons. A humanitarian of unusual ability, self-sacrifice, and empathy. Emeritus chief of staff, and emeritus chief of surgery at St. Mary's Hospital, Racine, Wisconsin. Presented June, 1961, by the Community of Franciscan Sisters, Daughters of the Sacred Heart of Jesus and Mary, in grateful appreciation for exceptional services beyond the call of duty."



Bronze plaque presented to Dr. Louis E. Fazen, Sr.

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NEWS FROM THE MEDICAL SCHOOLS

Pharmacology Grant to UW

The University of Wisconsin has been given one of the largest training grants in the country, $106,999, from the National Institutes of Health. It will be followed with additional NIH grants to pharmacology of $85,714 each year for another four years.

For UW's department of pharmacology and toxicology in the medical school, the grant means support for one more permanent staff member, seven pre-Ph.D. trainees, and five post-doctoral trainees. Dr. Frederick E. Shideman, chairman of the department, said the support would also mean $25,000 for equipment and the establishment of an additional graduate course in pharmacodynamics.

The University of Wisconsin has one of the oldest and most active pharmacology departments in the nation.

UW's pharmacology department received a boost last year with a move into the modern Medical Sciences Building. More than a dozen research programs are under way with a research and teaching staff of about 40. Drug treatment for cancer, heart and kidney disease as well as research in a number of other areas is being explored and will be expanded under the new NIH grant.

The work is needed. Between 1940 and 1955 one textbook list of drugs increased 70 per cent. New drugs are appearing so rapidly that the pharmacologist is unable to keep up with assessing their effects on the human body. Even the action of such well-known compounds as ether and alcohol is not completely understood.

Doctor Shideman says: "If we know how drugs act, we are in a position to make suggestions for better, safer and more effective drugs." This is the challenge modern pharmacologists are facing.

Marquette Grant Aids Research Center

A clinical research center for intensive, controlled study of patients with medical problems will be established at the Milwaukee County Hospital under a $200,000 grant awarded by the U.S. Public Health Service to the Marquette medical school. The announcement of the project and award was made jointly by Dr. H. M. Coon, County hospital administrator, and Dr. John S. Hirschboeck, medical school dean.

The grant, largest of its kind ever made at the Marquette medical school, was awarded to Dr. William W. Engstrom, Director of Medicine at the County hospital and Professor and Chairman of Medicine at Marquette. Doctor Engstrom conceived the idea of the Center and coordinated efforts of the faculty and staff of the hospital and school in securing the award.

Under the grant a 10-bed ward and special laboratory will be set up for special study of patient problems. Dr. Edward J. Lennon, faculty member in the department of medicine, is the program director for the Center.

An Artificial Kidney Unit was dedicated at University Hospitals on June 14. The special equipment including the Artificial Kidney Machine was purchased from a grant given by the Oscar Rennebohm Foundation. The unit has been in operation for several months. The Artificial Kidney is used for life-saving purposes in acute kidney failure. Dr. Ovid O. Meyer, professor and chairman of the Department of Medicine, and Mr. Oscar Rennebohm are shown with the plaque commemorating the dedication of this unit.

Dedication for Artificial Kidney Unit

A formal dedication ceremony for the new Artificial Kidney Unit at the University Hospitals, Madison, was held June 14, according to Mr. Edward J. Connors, Superintendent of the University Hospitals. A bronze plaque acknowledging the support of this project by the Oscar Rennebohm Foundation was presented by Dr. O. O. Meyer, professor and chairman of the Department of Medicine.

A Rennebohm Foundation grant of $5,000 provided funds to purchase the Kolff Twin Coil Artificial Kidney as well as other necessary equipment and supplies during the fall of 1960.

Remodeling of a former four-bed ward on the medical service of the University Hospitals was completed on March 15. The first patient with acute renal failure was treated within a few days after the unit was completed. In addition to the management of acute renal failure, the Artificial Kidney has been demonstrated to be life saving in a number of severe drug intoxications such as barbiturates, salicylates and Doriden poisoning.

Training of personnel assigned to the unit has been carried out in the Cardiovascular Research Laboratories of the Medical Center under the supervision of Dr. Arvin B. Weinstein, Assistant Professor of Medicine, who is in charge of this program.

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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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New Chairman of OB–GYN, Marquette

Dr. Richard F. Mattingly, assistant professor of obstetrics and gynecology at Johns Hopkins University, Baltimore, Md., has been appointed professor and chairman of obstetrics and gynecology at the Marquette University School of Medicine, Milwaukee. Announcement of his appointment was made by Dr. John S. Hirschboeck, Marquette medical dean.

Doctor Mattingly succeeds Dr. Roland S. Cron to the post as department chairman and assumed his duties with the medical school July 1. Doctor Cron is retired, after 36 years association with the Marquette medical faculty.

Doctor Mattingly has been associated with Johns Hopkins hospital and medical school since finishing his internship and residency there in 1956.

A native of Zanesville, Ohio, he is a Diplomate of the American Board of Obstetrics and Gynecology and a Fellow of the American College of Obstetrics and Gynecology.

UW Receives Medical Genetics Grant

A grant of $641,233 over a seven-year period for support of a research center in medical genetics has been made to the University of Wisconsin by the National Institutes of Health, and the first installment of $53,233 for 1961–62 was accepted by the UW Board of Regents May 12.

One of the first such grants made by NIH, the funds will be a major contribution to the rapidly developing program in medical genetics at Wisconsin.

A new $1,790,025 Genetics Research Building also is planned for the departments of genetics and medical genetics.

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Frank H. Urban, 425 East Wisconsin Avenue, Milwaukee, Wisconsin.
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MEDICAL MEETINGS—POSTGRADUATE COURSES

UW Postgraduate Course

A postgraduate course on Physiological Correlates of Psychological Disorder will be held August 29–31 at the University of Wisconsin Medical Center. The conference will be concerned with qualitative and quantitative aspects of physiological change which occurs in various kinds of mental disorder. Emphasis will be placed on ongoing work in terms of findings, methodological problems and indicated directions of future research.

The keynote address will be given by William Malamud, M.D., professional and research director, National Association for Mental Health, Inc., Tuesday morning, August 29, at 9 o'clock.

Faculty includes: Albert F. Ax, Ph.D., director, Psychophysiology Laboratory, Lafayette Clinic; John W. Lovett Doust, M.D., associate professor of psychiatry, University of Toronto; David T. Graham, M.D., associate professor of medicine, UW Medical Center; Norman S. Greenfield, Ph.D., associate professor, Dept. of Psychiatry and Wisconsin Psychiatric Institute, UW Medical Center; Joseph H. Handlon, Ph.D., research psychologist, National Institute of Mental Health; Thomas H. Holmes, M.D., professor of psychiatry, University of Washington; William Malamud, M.D.; Donald Oken, M.D., assistant director, Institute for Psychosomatic and Psychiatric Research and Training, Michael Reese Medical Center;

Harold Persky, Ph.D., associate professor, Institute of Psychiatric Research, Indiana University Medical Center; William Pollin, M.D., chief, Section on Psychiatry, Laboratory of Clinical Science, National Institute of Mental Health; Robert Roessler, M.D., professor and chairman, Dept. of Psychiatry, director, Wisconsin Psychiatric Institute, UW Medical Center; Charles Shagass, M.D., professor of psychiatry, State University of Iowa Medical School; Albert Stunkard, M.D., associate professor of psychiatry, University of Pennsylvania; Garfield Tourney, M.D., assistant director in charge of education, Lafayette Clinic; Herbert Weiner, M.D., assistant professor of psychiatry, Albert Einstein College of Medicine; and Marion A. Wenger, Ph.D., professor of psychology, University of California.

For further particulars write: Coordinator of Postgraduate Medical Education, The Wisconsin Center, 702 Langdon Street, Madison 6, Wisconsin.

Fall Cancer Scrimmage at UW

The Seventh Annual Fall Cancer Scrimmage will be held at the University of Wisconsin Medical Center Saturday, September 30. This meeting is cosponsored by the Cancer Research Section, Department of Surgery, of the Medical School and the Wisconsin Division of the American Cancer Society. A featured out-of-state cancer speaker will follow reports and papers on clinical cancer subjects.

A noon luncheon and football game (Michigan State) complete the day. Reservation slips and more details are being mailed in mid-August. R. J. Samp, M.D., University Hospitals, Department of Surgery, and Medical Director of the Wisconsin Division of the American Cancer Society, is arranging the meeting.

UW Postgraduate Course in Anesthesia

"Anesthesia for Today and Tomorrow" will be the topic of a postgraduate course September 28–30 at the University of Wisconsin Medical Center, Dr. O. S. Orth, chairman of the Department of Anesthesiology, is program chairman. A thorough review of new regional and general anesthetic agents and techniques introduced during the past decade will be made. There use with proper maintenance of physiological conditions will be stressed. Summarization of other agents, which still have advantages in modern day anesthesia practice, will be given. Prediction of future trends of advancement will be attempted.

For further information write: Coordinator of Postgraduate Medical Education, The Wisconsin Center, 702 Langdon Street, Madison 6, Wisconsin.

Psychiatry Course at UW Medical Center

A postgraduate course on Psychiatry for the General Physician will be held October 13–14 at the University of Wisconsin Medical Center under direction of Dr. Robert Roessler, chairman of the Department of Psychiatry and director of the Wisconsin Psychiatric Institute. This course will present emotional problems frequently seen in the general practice of medicine. The diagnosis, treatment and means of understanding these patients will be discussed. Emphasis will be on practical rather than theoretical views of these problems.

For further information write: Coordinator of Postgraduate Medical Education, The Wisconsin Center, 702 Langdon Street, Madison 6, Wisconsin.

American College of Surgeons

Latest applications of surgical research and new surgical techniques will be described at the world's largest meeting of surgeons, the 47th annual Clinical Congress of the American College of Surgeons, in Chicago October 2–6.

American Cancer Society Session

The 1961 scientific session of the American Cancer Society will be held October 23–24 at the Biltmore Hotel in New York City. The topic is: THE PHYSICIAN AND THE TOTAL CARE OF THE CANCER PATIENT. For further information write: Professional Education Section, American Cancer Society, 521 West 57 Street, New York 19, N.Y.

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No patient developed voracious appetite on triamcinolone. Preferable for the overweight person whose appetite is undesirably stimulated by other steroids. (Freyberg, R. H.; Berntsen, C. A., Jr., and Hellman, L.: *Arthritis & Rheumatism* 1:215 [June] 1958.)

SPECIAL PROBLEM: EDEMA

Since it does not produce edema, triamcinolone is useful in rheumatoid arthritis patients with cardiac decompensation who need steroid therapy. (Hollander, J. L.: *J.A.M.A.* 172:306 [Jan. 23] 1960.)

SPECIAL PROBLEM: HYPERTENSION

Triamcinolone may be included among the currently available antirheumatic steroids having the least tendency to cause sodium retention. (Ward, L. E.: *J.A.M.A.* 170:1318 [July 11] 1959.)

Hypertension did not result from triamcinolone therapy. Existing hypertension was reduced sometimes. This may have been due to lack of sodium retention. (Freyberg, R. H.; Berntsen, C. A., Jr., and Hellman, L.: *Arthritis & Rheumatism* 1:215 [June] 1958.)

Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. In the treatment of rheumatoid arthritis, dosage should be individualized and kept at the lowest level needed to control symptoms. Dosage should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

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U. S. Civil Defense Council Meeting

The 10th Annual Conference of the United States Civil Defense Council will be held on October 16–20 in Los Angeles. Wisconsin physicians, in and around the area of Los Angeles during this time, are especially urged to attend the meetings of the Health Committee. Any doctors of this state with any civil defense role or responsibility are urged to attend.

Further information on the meeting to be held in the Ambassador Hotel is available through the local Civil Defense Directors. Physicians who have an active part in civil defense programming may be eligible for a three-day course on "Decision Making in Emergencies," which will be conducted before and after the 10th annual meeting in Alameda, California. Under special arrangements with the Office of Civil and Defense Mobilization (OCDM) a portion of travel expenses and other expenses are reimbursable for those who attend this training course.

CIRCUIT TEACHING PROGRAMS

1961

Sept. 27: St. Joseph's Hosp., Menominee, Mich.
Sept. 28: Riverside Mem. Hosp., Waupaca
Oct. 3: Marine Club, Ashland
Oct. 4: St. Mary's Hosp., Rhinelander
Nov. 1: St. Joseph's Hosp., Dodgeville
Nov. 2: St. Joseph's Hosp., Beaver Dam

1962

Jan. 31: Vernon Mem. Hosp., Viroqua
Feb. 1: Divine Savior Hosp., Portage
Feb. 21: Lakeland Hosp., Elkhorn
Feb. 22: Oconomowoc Mem. Hosp., Oconomowoc

For further details, write State Medical Society. Box 1109, Madison 1, Wis.

PROBLEMS OF THE NEWBORN

St. Mary's Hospital, Wausau—Wednesday, September 13, 1961

MODERATOR: *A. H. Stahmer, M.D.*, President-Elect, Wiscansin Academy af General Practice

PROGRAM

P.M.

1:00 Registration

1:30 PROBLEMS OF THE NEONATAL PERIOD: *Robert M. Kass*, M.D., Wausau

1:40 DIAGNOSIS AND MANAGEMENT OF FETAL DISTRESS IN LABOR: *John Evrard*, M.D., Milwaukee

2:00 INFLUENCE OF ANESTHETIC AGENTS IN THE NEWBORN (The Critical Three Minutes After Birth): *Roger L. Hepperla*, M.D., Milwaukee

2:20 INFANT APPRAISAL AND IMMEDIATE POSTPARTUM CARE: *Kenneth J. Winters*, M.D., Milwaukee

2:35 RESPIRATORY DISTRESS SYNDROME: Medically—*Warren Rudy*, M.D., Wausau; Surgically—*Tague Chisholm*, M.D., Minneapolis, Minn.

3:15 Questions on first four topics

3:35 Coffee break

4:00 THE Rh FACTOR AND TRANSFUSION PROBLEMS: *Rex Ruppa, M.D.*, Milwaukee

4:20 SURGICAL PROBLEMS OF THE NEWBORN: *Tague Chisholm*, M.D., Minneapolis, Minn.

4:50 INFECTIONS AND USE AND MISUSE OF DRUGS: *Thomas V. Geppert*, M.D., Madison

5:10 Questions

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Co-Spansars: The Bureau af Maternal and Child Health of the State Board of Health and the Wisconsin Valley Chapter of the Wisconsin Academy of General Practice *

* This program provides 4 hours of Category I credit.

WISCONSIN CALENDAR COMING EVENTS

1961

Aug. 29–31: UW Postgraduate course, Psychiatric symposium, Dr. R. Roessler, chrm., Wisconsin Center Building, Madison.

Sept. 13: Special Conference on Problems of the Newborn, St. Mary's Hospital, Wausau.

Sept. 18–19: Annual meeting, Wisconsin Academy of General Practice, Milwaukee.

Sept. 28–30: UW postgraduate course, Anesthesiology, Dr. O. S. Orth, chrm., University Hospitals, Madison.

Sept. 30: Fall cancer scrimmage, UW Medical Center, Madison.

Oct. 13–14: UW postgraduate course, Psychiatry, Dr. R. Roessler, chrm., Wisconsin Center Building, Madison.

Oct. 19–20: Milwaukee Medical Conference, Milwaukee County Hospital.

Oct. 23–24: Scientific session, American Cancer Society, New York City.

Nov. 13–17: Annual meeting, American Public Health Association, Detroit, Mich.

Nov. 16–18: UW postgraduate course, Rehabilitation of Patients with Injuries of the Spinal Cord, Dr. A. Siebens, chrm., Wisconsin Center Building, Madison.

Nov. 28–Dec. 1: AMA Clinical Meeting, Denver, Colorado.

1962

Apr. 5–7: UW postgraduate course, Genetics in Pediatrics, Drs. J. Crow and N. Smith, co-chrm., Wisconsin Center Building, Madison.

Apr. 26–28: UW postgraduate course, Psychosomatic Medicine, Dr. David Graham, chrm., Wisconsin Center Building, Madison.

May 8–10: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 10–11: UW postgraduate course, Orthopedic Surgery, Dr. H. Wirka, chrm., Wisconsin Center Building, Madison.

May 17–19: UW postgraduate course, Anatomy, Physiology and Pathology of the Holocrine, Apocrine and Eccrine Glands, Dr. S. Johnson, chrm., Wisconsin Center Building, Madison.

June 11–15: AMA Annual Meeting, Chicago, Illinois.

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California.

American Fracture Association

The 22nd annual meeting of the American Fracture Association will be held Sept. 16–23 at the Shoreham Hotel in Washington, D.C. The meeting is acceptable for Category II credit by the American Academy of General Practice.

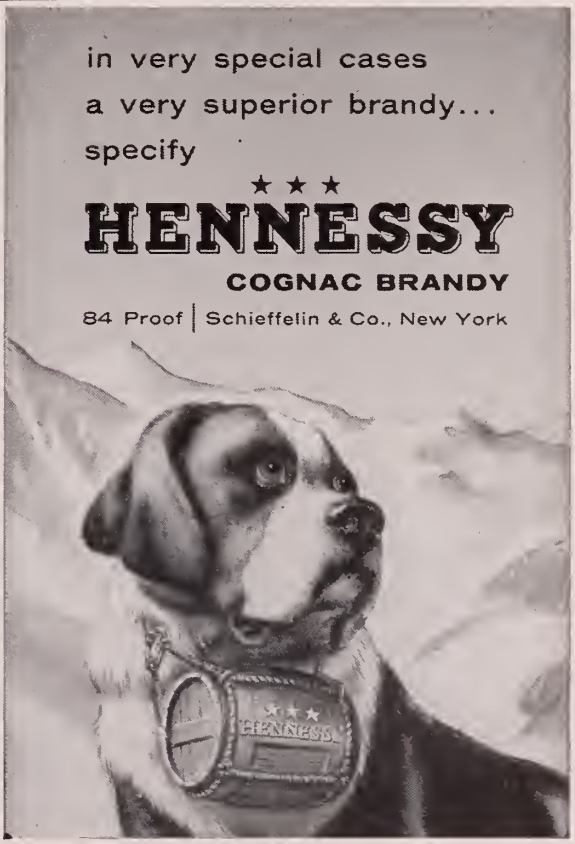
A postgraduate course at the Georgetown University Medical Center on Sunday, Sept. 17, will be acceptable for Category I by the AAGP.

1962 ANNUAL MEETING STATE MEDICAL SOCIETY MILWAUKEE

Tuesday, May 8:
- Internal Medicine
- OB & GYN
- Pathology
- Psychiatry

Wednesday, May 9:
- General Practice
- Orthopedic Surgery
- Pediatrics
- Pulmonary Diseases

Thursday, May 10:
- Anesthesiology
- EENT
- Radiology
- Surgery



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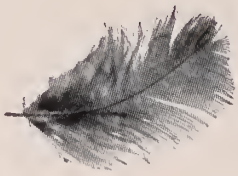

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References: 1. Santos, I. M. H., and Unger, L.: Ann. Allergy 18:172 (Feb.) 1960. 2. Charlton, J. D.: Ann. Allergy, in press. 3. Shaftel, H. E.: Clin. Med. 7:1841 (Sept.) 1960.

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VOL. 60, NO. 9—SEPTEMBER 1961

STATE MEDICAL SOCIETY OF WISCONSIN
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P R O G R E S S I N R E S E A R C H F O R M E D I C I N E

COUNTY SOCIETY PROCEEDINGS

ASHLAND–BAYFIELD–IRON

Members of the Ashland–Bayfield–Iron County Medical Society met June 13 in Ashland with *Dr. H. V. Sandin*, president, presiding. During the business session *Dr. Joseph M. Jauquet*, Ashland, reported on the actions taken by the House of Delegates at the annual meeting of the State Medical Society in May. *Dr. C. A. Grand*, Ashland, discussed the Charitable, Educational and Scientific Foundation's annual report presented at the state society meeting.

A motion made by *Dr. J. W. Prentice*, Ashland, was passed whereby the president was named to appoint three physicians to set up an adult tetanus toxoid immunization program. Appointed to the committee were Drs. J. W. Prentice, chairman, Dr. C. A. Grand and *Dr. Harold Guzzo*, Washburn.

Doctor Grand read a letter from the Red Cross regional blood bank at St. Paul pertaining to hemoglobin determinations.

Dr. W. J. Smiles, Ashland, presented the scientific program on "Closed Chest Cardiac Resuscitation."

BARRON–WASHBURN–SAWYER–BURNETT

Ten members of the Barron–Washburn–Sawyer–Burnett County Medical Society were hosts to their wives at the monthly meeting held June 13. During the meeting it was decided to invite Congressman Lester Johnson to speak at the group's October meeting.

GRANT

Dr. Kenneth E. Lemmer and *Dr. Sture A. M. Johnson* of the University of Wisconsin Medical School, Madison, were guest lecturers at the July 13 meeting of the Grant County Medical Society held in Lancaster. Doctor Lemmer, professor in the department of surgery, discussed "Anomalies and Surgery of the Pancreas" while Doctor Johnson, professor in the department of medicine (dermatology), talked on "Scratches In and For GP's." Their appearance was sponsored by the CES Foundation Speakers' Bureau under a grant by Merck Sharp & Dohme.

IOWA

Dr. John Allen, Madison, medical consultant in the State Department of Public Welfare, was a guest speaker at the August 8 meeting of the Iowa County Medical Society, held at the Dodge Point Country Club. The group discussed use of medical advisory committees and use of generic drug formulary for welfare patients, and the Kerr–Mills Act.

LAFAYETTE

The Lafayette County Medical Society and the Lafayette County Health Committee have approved a program of encouraging health examinations periodically during the school life of a child. Recommendations for examinations are before entering school, before entering fourth grade and before entering seventh grade.

MILWAUKEE

The first annual Milwaukee Medical Conference, sponsored by The Medical Society of Milwaukee County, will be held October 19 and 20 at Milwaukee County General Hospital. Details of the program are published elsewhere in this issue.

Members of the Society met in joint session with the Milwaukee Bar Association and the Greater Milwaukee Dental Association for a social event on August 17. Wives were also in attendance at the event which was held in the Wisconsin Club garden. Guest speaker was United States Senator Ernest Gruening, M.D., of Alaska. Senator and Mrs. Alexander Wiley and Senator and Mrs. William Proxmire were special guests.

OCONTO

Dr. J. F. March, Algoma, addressed the Oconto County Medical Society on the subject of coronary heart disease at its May 16 meeting in Oconto. His appearance was under auspices of the CES Foundation Speakers' Bureau under a grant by Wisconsin Heart Association.

OZAUKEE

Members of the Ozaukee County Medical Society heard *Dr. Gerald A. Kerrigan*, Milwaukee, speak on "Pediatric Fluid Therapy" at their June 22 meeting held at Grafton. His appearance was sponsored by the CES Foundation Speakers' Bureau under a grant by State Board of Health.

PIERCE–ST. CROIX

The June 20 meeting of the Pierce–St. Croix County Medical Society was held at River Falls. *Dr. John H. Flinn*, associate professor of medicine and director of student health, University of Wisconsin Medical School, Madison, talked on "Is Rheumatoid Arthritis an Auto-immune Disease?" His appearance was sponsored by the CES Foundation Speakers' Bureau. Also included in the program was a colored film on "African Safari" by Frank "Buck" Quattlebaum.

The July 18 meeting was held at *Dr. O. H. Epley's* cottage on Half Moon Lake.

On August 15 the Society met in Menomonie.

PORTAGE

The Portage County Medical Society on June 8 endorsed a proposal for establishment of a psychiatric guidance clinic to serve the Portage–Wood County area. In endorsing the project, the Society

Physicians whose names appear in italic are members of the State Medical Society.

offered its assistance in any way that would be helpful in bringing the "needed facility to this area."

In expressing its endorsement, the Society stated its approval of the mental program proposed by the Joint Commission on Mental Illness and Health. This Commission was founded in 1955 under the leadership of the American Medical Association and the American Psychiatric Association. The Society pointed out that the national health program proposed could revolutionize public care of persons with major mental illnesses.

Included in this program is a recommendation that there should be one fully-staffed, full-time mental health clinic for each 50,000 population. The bi-county clinic proposed in the Portage–Wood area is being planned as a reasonable method of overcoming some of the difficulties such as attracting capable personnel to staff the facility.

PRICE–TAYLOR

New officers of the Price–Taylor County Medical Society elected at the May meeting are: *Dr. Walter E. Niebauer*, president, and *Dr. John L. Rens*, secretary–treasurer. Both are from Phillips. Doctor Niebauer succeeds *Dr. W. W. Meyer* of Medford. *Dr. J. D. Leahy*, Park Falls, was the acting secretary.

Mr. Tom Doran, claims director, Wisconsin Physicians Service, was present at the meeting and offered suggestions on several matters.

RICHLAND

Members of the Richland County Medical Society heard *Dr. Peter B. Golden*, Madison, talk on "Fractures of the Elbow" at their July 6 meeting at Richland Center. Doctor Golden, a practicing orthopedist, was sponsored by the CES Foundation Speakers' Bureau under a grant by Merck Sharp & Dohme.

SHEBOYGAN

At a quarterly meeting held July 25 at Sheboygan, the Sheboygan County Medical Society endorsed the principle of a unified city-county public health department which had been a major topic of discussion for several months. The Society action reversed an April expression against such a public health movement on the basis that the plan would be too costly and too political. The endorsement was made following a report made by the Society's public policy committee composed of *Dr. James Hildebrand*, Sheboygan, president; *Dr. John Martineau*, Elkhart Lake; *Dr. Joseph Kovacic*, Sheboygan; and *Dr. Donald Rowe*, Kohler.

WAUKESHA

Members of the Waukesha County Medical Society conducted polio clinics on June 3 and July 8. On these dates polio immunizations were given at $2.00 per injection. Appointments were made in advance with individual physicians at their offices.

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Milwaukee Neuro-Psychiatric Society

Dr. Jules D. Levin has been installed as president-elect of the Milwaukee Neuro-Psychiatric Society. *Dr. Lloyd F. Jenk* is president of the organization. Other officers named by the Society are: secretary, *Dr. James R. Hurley*, and treasurer, *Dr. Joseph E. Weber*. *Dr. Christopher J. Buscaglia*, Dr. George J. Martin and *Dr. Francis J. Millen* were elected Councilors.

Wisconsin Society of Internal Medicine

Members of the Wisconsin Society of Internal Medicine met Sept. 15 and 16 at King's Gateway Hotel in Land O'Lakes for its annual meeting, including a scientific program, postgraduate course and business session. Program chairman was *Dr. Edward K. Ryder, Jr.*, Madison.

Scientific sessions started Friday morning, Sept. 15, and featured "Pathogenesis and Immunology of Rheumatoid Arthritis." Lecturers included Dr. Arthur L. Scherbel, head of medicine, Rheumatic Disease Section, Cleveland Clinic and Cleveland Clinic Hospital, Cleveland, O.; *Dr. Helen A. Dickie*, associate professor of medicine, University of Wisconsin Medical Center, Madison; *Dr. John H. Flinn*, associate professor of medicine and director of student health, University of Wisconsin Medical Center, Madison; and *Dr. Philip G. Piper*, assistant clinical professor of pathology, Madison General Hospital, Madison.

The annual business meeting was conducted during a buffet luncheon Friday noon.

Doctor Scherbel also presented the William S. Middleton Lecture in the afternoon. His topic was "Role of Serotonin in Connective Tissue Diseases."

Dr. Ross V. Taylor, Jackson, Mich., president of the American Society of Internal Medicine, reported on "The Role of the American Society of Internal Medicine." Also in the afternoon a panel discussion was presented on the subject "Care of the Aged." Moderator was *Dr. Robert L. Gilbert*, La Crosse, president of the Wisconsin Society; Dr. Ross V. Taylor, Jackson, Mich.; *Dr. Robin N. Allin*, Madison; *Dr. A. A. Quisling*, Madison; and *Dr. Adolph Hutter*, Fond du Lac, were panelists.

Friday evening was devoted to a social hour, dinner and a program of entertainment for both physicians and wives. Installation of newly elected officers was also held.

A day-long postgraduate course on recent developments in the field of hematology was presented Saturday, Sept. 16. *Dr. George E. Gutmann*, Janesville, chairman of the Postgraduate Education and Research Committee, directed the program.

During the morning *Dr. Armand J. Quick*, professor and chairman of the Department of Biochemistry, Marquette University School of Medicine, Milwaukee, presented the subject "Recent Coagulation Studies;" *Dr. Ovid O. Meyer*, professor and chairman, Department of Medicine, University of Wisconsin Medical School, Madison, discussed "Anticoagulation Therapy—Uses and Abuses."

In the afternoon a report on "Recent Studies in Antibody Formation" was given by *Dr. Anthony V. Pisciotta*, associate professor of medicine, Marquette University School of Medicine, Milwaukee. *Dr. Robert F. Schilling*, associate professor of medicine, University of Wisconsin Medical Center, Madison, discussed "Familial Hemolytic Anemia." Dr. Nathan J. Smith, professor and chairman, Department of Pediatrics, University of Wisconsin Medical School, Madison, talked on "Obscure Anemias in Childhood."

Panel discussions of actual cases were presented in both the morning and afternoon sessions.

Wisconsin Academy of General Practice

Dr. Edward R. Annis, Miami, Florida, was the featured speaker at the annual meeting of the Wisconsin Academy of General Practice in Milwaukee, Sept. 17–19. The three-day meeting was held at the Milwaukee Auditorium and the Hotel Schroeder.

Doctor Annis, well known for his television debates with Walter Reuther on medical care for the aged and the private practice of medicine, spoke at the annual banquet Monday evening, Sept. 18. He is a graduate of Marquette University School of Medicine.

Doctor Annis also presented a scientific paper on "Endometriosis from the Standpoint of a General Surgeon."

1962 ANNUAL MEETING STATE MEDICAL SOCIETY MILWAUKEE

Tuesday, May 8:
- Internal Medicine
- OB & GYN
- Pathology
- Psychiatry

Wednesday, May 9:
- General Practice
- Orthopedic Surgery
- Pediatrics
- Pulmonary Diseases

Thursday, May 10:
- Anesthesiology
- EENT
- Radiology
- Surgery

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NEWS OF WISCONSIN PHYSICIANS

Internist Joins Quisling Clinic

Dr. Paul L. Davidson, Boston, Mass., recently joined the Department of Internal Medicine at the Quisling Clinic, Madison. Doctor Davidson was graduated from Harvard in 1950, and in 1954 received his M.D. degree at the College of Physicians and Surgeons, Columbia University. He interned and served his residency in internal medicine in Boston hospitals.

Doctor Bowers Speaks at Fond du Lac

Dr. John Z. Bowers, dean of the University of Wisconsin Medical School, Madison, was the main speaker at an all-day Community Chest campaign clinic held August 1 at Fond du Lac. He discussed various aspects of medical and health research, and the problems in financing the research.

Joins Madison Physicians' Office

Dr. C. R. Jackson has joined the office of *Drs. T. A. Leonard, William Luetke* and *R. E. Whitsitt*, Madison, in the practice of obstetrics and gynecology. Doctor Jackson graduated from Gustavus Adolphus College, St. Peter, Minn., and the Jefferson Medical College, Philadelphia, Pa. He was a resident at University Hospitals, Madison, from 1957 to 1961. During the past year he was the American Cancer Society Fellow in gynecology. He will continue on the clinical faculty at the University.

Psychiatrist Joins Sheboygan Clinic

Dr. Earl H. Jochimsen, a native of New Holstein, has joined the Sheboygan Clinic staff in the department of psychiatry. He received his medical degree from the University of Wisconsin in 1953. His internship was completed at Milwaukee Hospital and thereafter he served as a staff physician at Mendota State Hospital, Madison, from July 1954 to March 1955. He then served in the U. S. Navy until he began his residency training in July 1957 at the University of Wisconsin Medical School, department of psychiatry, which he completed in June 1960. During the past year he again served as a staff physician at Mendota hospital and is eligible for certification in the American Board of Psychiatry.

Doctor Dean Opens Madison Office

Dr. David L. Dean, a native of Madison, has opened an office in that city after practicing in California for two years. He will specialize in surgery. Doctor Dean is the son of *Dr. James P. Dean*, who practiced many years in Madison. After receiving his medical degree from the University of Wisconsin, he interned at Cincinnati General Hospital, and had four years of training in surgery at the Mayo Clinic, Rochester, Minn. He is certified by the American Board of Surgery and is a Fellow in the American College of Surgeons.

Opens Urology Practice in Sheboygan

Dr. Christopher A. Graf recently began the practice of urology at Sheboygan. He is a graduate of the University of Wisconsin, receiving his bachelor of science degree in 1951 and his doctor of medicine degree in 1954. Doctor Graf interned at St. Joseph's Hospital in Marshfield before spending two years in the U. S. Army.

Doctor Angevine Given Award

Dr. D. Murray Angevine, chairman of the department of pathology, University of Wisconsin Medical School, Madison, was recently awarded $7,192 by the Muscular Dystrophy Associations of America for continued studies of muscle tissue.

New Ashland Clinic Affiliation

Physicians of the C. J. Smiles Medical Group and *Drs. J. W. Prentice* and *B. C. Prentice*, all of Ashland, formed a new association August 1. They will be known as The Smiles–Prentice Medical Group. Other physicians in the group are *Dr. Frank D. Weeks, Dr. W. E. Bargholtz, Dr. John E. Kreher*, and *Dr. William J. Smiles*.

Join Monroe Clinic Staff

Dr. Lewis F. Scribner, Jr. has joined the Monroe Clinic in the department of allergy and Dr. N. Peter Braun, in the department of orthopedic surgery.

Doctor Scribner came to Monroe from Boston where he received his fellowship in allergy at the Massachusetts General Hospital. Following graduation from Wayne University College of Medicine in 1954, he interned and took a residency in internal medicine at Wayne County General Hospital, Eloise, Mich.

Doctor Braun just completed three years of residency in orthopedic surgery at Cincinnati. Prior to that he had been chief resident in surgery at Lawrence Memorial Hospital, New London, Conn., for one year. Other surgical residencies were completed in England. Doctor Braun was born in Capetown, South Africa. He received his bachelor of surgery and bachelor of medicine degrees in Wales, Great Britain, in 1953.

New Chetek Medical Clinic Dedicated

The new Chetek Medical Clinic was dedicated July 30 as the climax of a civic drive to obtain additional physicians for the community through the availability of a modern medical facility. The State Medical Society's Placement Service assisted the community in locating two physicians to come to Chetek. Citizens were assisted in the planning of the center by the Sears-Roebuck Foundation. New physicians who will join *Dr. Robert W. Adams* in the clinic are Dr. Mac C. Roller and Dr. Joseph E.

Physicians whose names appear in italic are members of the State Medical Society.

Powell. Doctor Adams has served the community 30 years.

Both Doctor Powell and Doctor Roller are graduates of Indiana University. They have just completed internships at Denver, Colo.

Dr. Gunnar Gundersen, La Crosse, was one of the main speakers at the dedication. He is a member of the Sears Foundation committee as well as a past president of the American Medical Association.

Joins McDonald Clinic, Winneconne

Dr. Milo Sekulich has joined the McDonald Clinic at Winneconne after a residency in internal medicine at the VA Center, Wood. He is presently doing general practice at the clinic with *Dr. Donald McDonald.* Doctor Sekulich was born in Yugoslavia. He is a graduate of Marquette University School of Medicine, Milwaukee, class of 1959. His internship was completed at Resurrection Hospital, Chicago.

Opens Practice at Coleman

Dr. Edward F. Daley opened an office in Coleman early in July for the general practice of medicine with special interest in obstetrics and pediatrics. A graduate of the St. Louis University Medical School in 1951, Doctor Daley interned at Milwaukee County General Hospital and Emergency Hospital after which he practiced for six years at Green Bay and one year at Gillett.

Dr. Thomas Chisholm to Arcadia

Dr. Thomas Chisholm of Chippewa Falls began a medical practice September 5 at Arcadia. He is a 1959 graduate of Marquette University School of Medicine. He interned at Georgetown University Hospital in Washington, D. C., and has just completed a residency in general practice at St. Joseph's Hospital, Flint, Mich.

Dr. Irving Schiek, Sr. Honored

Dr. Irving E. Schiek, Sr., Rhinelander, was named an advisor to the president of North Central Airlines at a dinner meeting held in May in Rhinelander. Representatives of the airline were present. The honor was bestowed on him in recognition of his interest in the development of local airline service in the north central states and the invaluable support he has extended to North Central Airlines.

Plum City Has New Physician

Dr. James Terrano, who had been practicing in the coal-mining region of West Virginia, moved to Plum City early in June to begin a new practice. *Dr. Burt Erickson*, who had been practicing there, left April 1 to return to his native Colorado.

Doctor Balder Makes Plans for New Clinic

Dr. Roy Balder, Jr., who recently opened a full-time office in Elroy, is making plans for the construction of a new clinic building.

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WISCONSIN PHYSICIANS *continued*

New Physician for Hales Corners

Dr. Rudolph Balzer began practicing medicine in Hales Corners May 15. A native of Zagreb, Yugoslavia, he came to the United States in 1955. He had a fellowship at the Cleveland Clinic, later took a residency at Northwestern University, Evanston, Ill., and then started a practice in Milwaukee in 1958. He will continue to practice in Milwaukee as well as Hales Corners for at least a year.

Doctor Murphy Receives Honorary Degree

Dr. Francis D. Murphy, Wauwatosa, received an honorary degree, Doctor of Laws, at Marquette University's 1961 commencement exercises June 4. An alumnus of Marquette's medical school, he is emeritus professor of medicine at Marquette and chief of staff emeritus at St. Joseph's Hospital. The Francis D. Murphy chair of medicine was established in his honor at Marquette in 1957. He has been in practice since 1920.

Two Physicians Leave Platteville

Dr. Dale Everson, who practiced at Platteville, has moved to Shell Rock, Iowa, to join his sister in the practice of medicine.

Dr. M. L. McCumber left in June to enter a residency in orthopedic surgery on the West Coast.

Madison General Hospital Elections

Dr. George G. Stebbins of the Madison General Hospital medical staff has been elected to the board of directors of the Madison General Hospital and Surgical Foundation, Inc. Newly elected officers are *Dr. Thomas A. Leonard,* president; and *Dr. Peter B. Golden,* vice-president. *Dr. William B. Hobbins* will continue as secretary and treasurer. All are Madison physicians.

Joins Ripon Student Health Center

Dr. Stewart Lofdahl, a 1960 graduate of the Northwestern University Medical School, recently joined *Dr. William Schuler* in the Ripon College Student Health Center.

Attend AMA New York Meeting

Dr. and Mrs. *A. C. Engel,* New Holstein, attended the American Medical Association meeting held in New York City in June and then toured the New England states before returning home.

Doctor Rounds Boscobel Radiologist

Dr. Wayne M. Rounds of Middleton is now associated with the Boscobel Memorial Hospital as a visiting radiologist. Since 1959, Doctor Rounds has been in the private practice of diagnostic and therapeutic radiology in Madison. In addition to the Boscobel hospital, he is radiologist for the Wisconsin

MEDICAL STAFF
OWEN OTTO, M. D.
Medical Director
EUGENE FRANK, M. D.
WILLIAM C. JANSSEN, M. D.
LOREN J. DRISCOLL, M. D.
JOSEF A. KINDWALL, M. D.
Consultant
LEROY A. WAUCK, Ph. D.
Clinical Psychologist

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Dells Clinic, the Friendship Memorial Hospital and the Quisling Clinic in Madison.

Doctor Rounds is a 1943 graduate of the University of Wisconsin Medical School. He interned at Methodist hospital, Madison, spent 30 months in the U. S. Navy, practiced in Wausau four years, then took a residency in radiology at the University of Pennsylvania. He was director of the department of radiology at St. Mary's Hospital in Madison for four years before opening his private practice.

Doctor Bachhuber to Oregon

Dr. Thomas E. Bachhuber, who just completed three years of residency at Wisconsin General Hospital, Madison, has joined the staff of a clinic in Portland, Ore., with orthopedic surgery as his specialty.

Joins Staff of Sparta Clinic

Dr. Paul Albrecht of St. Paul, Minn., has joined the staff of the Sparta Clinic and St. Mary's Hospital. He served his internship at Bethesda Lutheran Hospital in St. Paul. He is a 1960 graduate of the University of Minnesota Medical School.

Physicians at Westby in New Quarters

Drs. P. T. Bland and *W. N. Otterson* have moved into a new medical-dental building at Westby. An interesting feature of the interior of the building is the waiting room which has settees and desks built and finished by Doctor Bland from rough black cherry wood.

Brandon Has New Physician

Dr. Harold G. Adams has moved into his new 12-room medical center building in Brandon. The Brandon community had spent six months locating a physician. Doctor Adams moved to Brandon from Tomahawk where he had an established practice. He received his pre-medical training from the University of Wisconsin and graduated in 1952 from Marquette University School of Medicine.

Doctor Wegner President Health Council

Dr. M. E. Wegner, St. Croix Falls, was elected president for the coming year of the Polk County Health Council at a meeting held in June at Amery.

Dr. Huber Speaks on Atomic Warfare

Dr. Robert Huber, St. Croix Falls' radiologist, spoke in June before a meeting of the Polk County Health Council on conditions and precautions necessary in case of an atomic attack.

Doctor Simenstad Honored

Dr. L. O. Simenstad, Osceola, was awarded a Distinguished Citizen Citation "in recognition of superior attainments in his chosen field of work and for devoted service to the cause of education and support

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of his alma mater" at a commencement banquet held in June at the University of North Dakota, Grand Forks.

Redgranite Has New Physician

Dr. Erick Schmidt, a graduate of the University of Berlin, Germany, is now practicing at Redgranite. The physician came to Waushara county from Winnipeg, Canada, where he had practiced for over four years. He practiced for ten years in Germany before moving to Canada.

Doctor Kreutzer to Madison

Dr. E. W. Kreutzer has taken over the practice of *Dr. S. P. Vinograd* at Madison. He was formerly in the medical service department of the Veterans Administration Hospital, Tomah. His practice is limited to internal medicine.

Joins Doctor Ashe at Minocqua

Dr. Theodore Fox, who just finished a general practice residency at McNeal Memorial Hospital, Berwyn, Ill., is now associated with *Dr. Henry Ashe* at Minocqua. He is a graduate of the University of Wisconsin Medical School. He took his internship at Oakland Naval Hospital and served three years in the U. S. Navy as a medical officer.

Grantsburg Physicians in New Quarters

Drs. R. L. Hartzell and *R. A. Cutshall* moved into new offices at Grantsburg in June.

Physician Changes at Ellsworth

Dr. A. R. Aanes has moved to Tucson, Ariz., after serving the Ellsworth residents for 24 years. The decision to move came after several vacation trips to Arizona and to Mexico.

Succeeding Doctor Aanes is *Dr. E. R. Jonas* of Minneapolis. He is a graduate of the University of Minnesota Medical School. His internship was served at Minneapolis General Hospital. Prior to entering the medical field, Doctor Jonas worked as a laboratory and x-ray technician at St. John's Hospital in Red Wing, his home, and at St. Barnabas Hospital in Minneapolis.

New Physician at Waupun Clinic

Dr. Martin F. Petereit joined the Waupun Clinic staff July 1. He just completed a general surgery residency at the Veterans' Administration Hospital at Fargo, N. D. He is a graduate of the University of Nebraska Medical School.

New Internist at Menomonee Falls

Dr. Jack R. Hoffman opened offices in July in the Doctor's Park Medical Group at Menomonee Falls for the practice of internal medicine. He just com-

pleted resident training at Milwaukee County Hospital. Before coming to Milwaukee, Doctor Hoffman spent two years with the Marine Corps from 1957 to 1959. Before that he interned for a year with the Youngstown, Ohio, Hospital Association. He is a 1955 graduate of Ohio State University Medical School, Columbus.

Doctor May Joins Baldwin Clinic

Dr. John May, a native of Earlville, Iowa, and a graduate of the University of Iowa Medical School, has joined *Dr. C. A. Olson* and *Dr. L. B. Torkelson* on the medical staff of the Baldwin Clinic. Doctor May's internship was spent at Miller Hospital in St. Paul, Minn. He is a veteran of four years service with the U. S. Navy.

Dr. Peters Takes Over Boutwell Practice

Dr. Earl E. Peters, formerly of Muscatine, Iowa, has taken over the practice of *Dr. W. S. Boutwell* at Doctors Park in Janesville. Doctor Boutwell is taking postgraduate work in anesthesiology. Doctor Peters, who was born in Michigan, received his doctor of medicine degree from the College of Medical Evangelists, Los Angeles, Calif., in 1953 and interned at Madison General Hospital, Madison. For the past six years he was in group practice in Muscatine. He also served in the Army Medical Corps.

Intern at Eau Claire Hospital

Dr. George M. Kopf has begun a one-year rotating internship at Luther Hospital, Eau Claire. A native of Chilton, Doctor Kopf received his medical degree from the University of Wisconsin Medical School.

Interning at Milwaukee Hospital

Dr. John J. Massart began his internship July 1 at St. Joseph's Hospital, Milwaukee. He graduated this year from Marquette University School of Medicine.

Doctor Keller Joins Sheboygan Clinic

Dr. Robert A. Keller of Kohler has joined the staff of the Sheboygan Clinic in the department of general practice and obstetrics. He received his bachelor of science degree in 1951 from the University of Wisconsin. Prior to entering medical school, he was employed at the McArdle Memorial Laboratory as a research assistant in oncology at the University in Madison. He received his medical degree in 1958. An internship was completed at Milwaukee Hospital.

Marshfield Clinic Adds Two Physicians

Two new physicians have joined the staff of the Marshfield Clinic. They are Dr. Stafford W. Gedge, an internist, and *Dr. Richard D. Sautter*, a thoracic surgeon.

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Doctor Gedge, born in New York City, received his medical degree in 1955 from Albany Medical College in Union University at Albany, N. Y., and served his internship at the Charles T. Miller Hospital in St. Paul, Minn. His studies in internal medicine were conducted at the Mayo Clinic, Rochester, Minn.

Doctor Sautter is from Nebraska where he received his medical degree in 1953 from the University of Nebraska College of Medicine. He interned at Highland-Alameda County Hospital in Oakland, Calif. The next four years were spent in general surgery residency at the University of Iowa Hospital. He also served on the teaching staff at Iowa University for one year and specialized in thoracic surgery for two years.

New Physician for Wautoma

Dr. Clarence A. Klasinski has joined *Dr. R. C. Darby* in the practice of medicine at Wautoma. The physician, who is originally from Stevens Point, is a 1960 graduate of Stritch School of Medicine at Loyola University in Chicago. Doctor Klasinski interned at St. Margaret Hospital, Hammond, Ind. He also did experimental research at the University of Chicago over a three-year period.

New Medical Team for Kenosha

A husband and wife medical team has begun practice in Kenosha. Dr. Walid Burhani and Dr. Dorothy Conzelman (Burhani) established their practice July 1 in the Kenosha Medical Center. Doctor Burhani is a general surgeon and Doctor Conzelman is a pediatrician.

Doctor Burhani, a Syrian, received his medical degree from King Edward Medical College, a British school in Pakistan. His internship was done at Wesley Memorial Hospital in Chicago and he did a four-year general surgical residency at Presbyterian-St. Luke's Hospital, Chicago.

Born in Waukegan, Ill., Doctor Conzelman graduated from Lake Forest College and the Woman's Medical College of Pennsylvania. She interned at Presbyterian-St. Luke's Hospital and did her pediatric residency there and at Children's Memorial Hospital in Chicago.

Doctor McKenna Associates with Father

Dr. John E. McKenna has opened a medical practice in Antigo in association with his father, *Dr. E. A. McKenna*. He is a 1957 graduate of the University of Wisconsin Medical School. He interned for one year at Highland-Alameda County Hospital in Oakland, Calif., and spent six additional months there as a medical resident. He then attended a six months' course at the Aviation School of Medicine at Pensacola, Fla., where he graduated as a flight surgeon in 1959. He enlisted in the Marine Corps and was stationed at Hawaii prior to returning to Antigo.

Doctor Chancey Fellow of ACP

Dr. Robert L. Chancey, Beloit, has been elected to fellowship in the American College of Physicians. Doctor Chancey, who came to Beloit Clinic in 1955, received his medical degree in 1952 from Emory University and did his residency and postgraduate training at Augusta, Ga., and Denver, Colo.

Dr. Schiek a Fellow in Surgeon Group

Dr. I. E. Schiek, Jr., Rhinelander, became a Fellow in the International College of Surgeons in May. He has practiced in Rhinelander since 1940 with his father.

Dr. I. M. Becker Honored

Dr. Irvin M. Becker, Milwaukee, was elected to membership in the American Gastroenterological Association at its annual meeting in Chicago, May, 1961.

Internist from Mayo Now in Milwaukee

Dr. William L. Treacy, who has been a fellow in internal medicine, in the Mayo Foundation in Rochester, Minn., is now located in Milwaukee.

Doctor Banyai National Speaker

Dr. Andrew L. Banyai, Chicago, Ill., clinical professor of medicine, emeritus, Marquette University School of Medicine, Milwaukee, was moderator of the Fireside Conference on "The Spectrum of Miliary Disorders of the Lung," held together with conferences on 25 other scientific subjects, under the joint sponsorship of the American Medical Association and the American College of Chest Physicians, in conjunction with their annual meetings in New York City on June 26.

Two Wisconsin Physicians Honored

Dr. Josef R. Smith and *Dr. Ross C. Kory* along with Lyle H. Hamilton, Ph.D., all of the Veterans Administration Center, Wood, received a certificate of merit for the "unusual excellent nature" of their exhibit on use of gas chromatography in the evaluation of pulmonary function at the recent annual meeting of the American Medical Association in New York City.

Doctor Gundersen Heads Blood Council

Dr. Gunnar Gundersen of La Crosse was elected as president of the Joint Blood Council at its annual meeting in New York June 26.

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WISCONSIN PHYSICIANS *continued*

Physician Changes at Whitehall Clinic

Dr. K. W. Halgrimson, who has been physician and manager of the Whitehall Clinic the past two years, left in July for Downey Veterans' Administration Hospital, Illinois, where he is studying psychiatry on a fellowship.

Drs. O. M. Schneider of Blair and *C. F. Meyer* of Independence are sharing the responsibility for all area care at the Whitehall Community Hospital and at the Clinic. They also head the committee for securing another physician for the area.

Elected to Cancer Society Board

Dr. Sam Salan, president of the Waupaca County Medical Society, was elected to the board of directors of the Waupaca County Cancer Society in July.

New Waukesha County Medical Director

Dr. Ruth E. Church, Springfield, Ill., has begun duties as medical director of the Waukesha county health department. She was previously head of the division of hospitals and chronic illness of the Illinois State Department of Health.

Another Trip for the "Maggie Lee"

Dr. Leland Pomainville, Wisconsin Rapids, and his 15-foot outboard motorboat "Maggie Lee" journeyed 700 miles on a cruise from New Orleans to Pensacola, Fla., the early part of June. He was accompanied by his son-in-law, Dr. Philip Hacker, and the latter's two medical school classmates. Doctor Pomainville had attended the graduation ceremonies of Doctor Hacker at Tulane University Medical School. This latest trip is only one of many in the "Maggie Lee's" six-year history. Her 75 h.p. motor has driven her more than 8,200 water miles, and she has traveled 15,000 more by trailer. All the places where the "Maggie Lee" has been are recorded on the side of the boat.

With the graduation of Doctor Hacker, the Pomainville family now has 10 physicians in three generations.

Milwaukee Eye Specialist to La Crosse

Dr. Carl F. Schmidt, an ophthalmologist who has been practicing in association with his father in Milwaukee, is now associated with the Gundersen Clinic and the La Crosse Lutheran Hospital at La Crosse. Doctor Schmidt is a 1956 graduate of the University of Wisconsin Medical School. He served his internship at St. Luke's Hospital, Chicago, and a three-year residency in ophthalmology at the University of Illinois Hospitals from 1957 to 1960.

Dr. Paul Biever, Port Washington, Weds

Dr. Paul Biever of Port Washington was married July 15 to Barbara Ann Trecker in a ceremony

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at Elm Grove. Doctor Biever, a graduate of Marquette University School of Medicine, recently completed three years of residency training at St. Joseph's Hospital in Milwaukee and will now join two partners in practice in Milwaukee specializing in obstetrics. His bride is a graduate of the Marquette School of Nursing.

Complete Internship at Marshfield Hospital

Three young physicians completed a year's internship at St. Joseph's Hospital Marshfield June 30. They are Drs. Allen Kind, River Falls, Thomas M. Kivlin, Madison, and Robert T. Guelcher, Port Edwards.

Doctor Kind has become a resident in internal medicine at the University of Wisconsin Medical School; Doctor Guelcher is now an Air Force physician; and Doctor Kivlin is in general practice at Oshkosh. Doctor Kind and Doctor Kivlin are Wisconsin medical school graduates while Doctor Guelcher attended the University of Buffalo Medical School.

Doctor Tenney Mental Health Speaker

Dr. H. Kent Tenney, Madison, was the keynote speaker at the annual mental health day July 25 at Platteville State College. His topic was "Providing a Healthy Environment for Our Children."

Doctor Nora Joins Beloit Clinic

Dr. James J. Nora, who received his medical degree at Yale University in 1954, joined the pediatric department of the Beloit Clinic in July. Doctor Nora served his internship at the Detroit Receiving Hospital and then did general practice at Cambridge. While there he studied his specialty at the University of Wisconsin. The past year he has been chief resident in pediatrics at University Hospitals, and now is clinical instructor in pediatrics at the university.

Speakers at West Allis Hospital Dedication

Dr. James M. Sullivan, Milwaukee, president of The Medical Society of Milwaukee County; *Dr. Carl N. Neupert,* Madison, State Health Officer; and *Dr. Julius M. Meyer,* chief of the medical staff of the new West Allis hospital, were guest speakers at the dedication ceremony of the West Allis Memorial Hospital August 6. The $6.5 million, 250-bed hospital was expected to open September 11 for patients in a maternity ward, according to William E. Claypool, administrator.

New Post for Milwaukee Pediatrician

Dr. A. B. Schwartz, at the age of 70 years, has withdrawn from private practice in Milwaukee to begin a new career as medical coordinator of the new diagnostic center of multiple-handicapped children at Milwaukee Children's Hospital.

Two La Crosse Physicians Blood Donors

Two La Crosse physicians have become three-gallon blood donors. *Dr. Robert E. McMahon* and *Dr. J. R. Richter* each completed their third gallons during the May visit of the Red Cross Bloodmobile. Their donations cover a period of 10 years.

Doctor Kuehn Viroqua Physician 30 Years

On July 1 *Dr. Alvin Kuehn* marked his 30th anniversary as a practicing physician in the Viroqua community. Doctor Kuehn received his medical education at the University of Iowa School of Medicine and then interned at Madison General Hospital, Madison.

Doctor Sander Home from South Africa

Dr. O. A. Sander, Milwaukee, recently returned from an international conference on pneumoconiosis held in South Africa. A specialist in chest diseases and industrial medical problems, Doctor Sander was one of three U. S. physicians who participated in the conference.

Doctor Menne Speaks at Rotary Club

Dr. Frank Menne, who lives in retirement at Peebles, spoke to the Fond du Lac Rotary Club in June. Medical advances in the United States in the last 50 years were described by Doctor Menne as unparalleled by any other time in the history of civilization. Doctor Menne served on the medical faculty at the University of Oregon and was consultant to about 25 hospitals in the northwestern part of the country before his retirement.

Doctor O'Connell Talks to Kiwanians

Dr. James O'Connell was speaker at a meeting of the Kiwanis Club of South Milwaukee recently. Doctor O'Connell represented the Milwaukee County Medical Society's speakers' bureau. He discussed the scientific viewpoints of the smoking-lung cancer situation.

Doctor Middleton at Wood VA Center

Dr. William S. Middleton, chief medical director of the Veterans Administration and a former dean of the University of Wisconsin Medical School, was one of the main speakers at the two-day VA area conference held at the Veterans Administration Center at Wood in June. The meeting concerned the problems of older veterans.

Owen Has New Physician

Dr. John Peden, Middletown, Conn., has established a practice at Owen. He succeeds *Dr. H. M. Braswell* who has left to join the student health staff at the University of Chicago and specialize in internal medicine. Doctor Peden is a native of Scotland and is a graduate of the Edinburgh University School of Medicine in 1959. After interning in a Connecticut hospital he was in private practice at Middletown.

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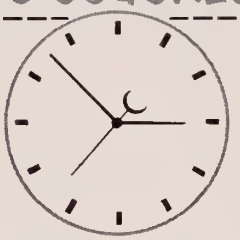

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WISCONSIN PHYSICIANS *continued*

Dr. Kalb Speaks at Mayo Clinic, Symposium

Dr. Clifford H. Kalb, Milwaukee, presented a paper on "Modular Patterns of Emulsions in Allergic Practice" at the meeting of the North Central Allergy Society at the Mayo Clinic, Rochester, Minn., April 29–30. Doctor Kalb also served as co-chairman of the Instructional Symposium held in Chicago on May 27–28 under the auspices of the American College of Allergists on the preparation and administration of emulsified allergenic extracts for repository use.

Honors to Dr. E. F. McNichols

Dr. Edwin F. McNichols, Janesville, was recently certified by the American Board of Internal Medicine. He also was recently elected to associate membership of the American College of Physicians. Doctor McNichols is a graduate of Loyola University Medical School, trained at Milwaukee County General Hospital, and has been practicing internal medicine for four years at Janesville.

Doctor Shideman Visits Stockholm

Dr. F. E. Shideman, chairman of the department of pharmacology and toxicology, University of Wisconsin Medical School, Madison, attended the first international pharmacological meeting in Stockholm, Sweden, August 22–25. Doctor Shideman presented a paper "A Species Difference in Metabolism of Myocardial Catecholamines." While on the trip, Doctor Shideman planned to visit the laboratories in Italy, Germany and Denmark.

Doctor Barreto Lectures in Argentina

Dr. Reinaldo S. Barreto, assistant professor of anesthesiology at the University of Wisconsin Medical School, Madison, in August presented a series of lectures regarding regional anesthesia at Rosario Medical School in Argentina. Doctor Barreto received his M.D. at the UW and had his residency in Buenos Aires.

Doctor Becker New WAA President

Dr. Norman O. Becker, Fond du Lac, was elected president of the Wisconsin Alumni Association for the 1961–62 year at the annual meeting June 3. He is the third medical man to be named to the presidency of the Association, and only the second to hold the office in the last 50 years.

Chest Physicians Receive Fellowships

Three Wisconsin physicians received fellowship certificates in the American College of Chest Physicians at the annual meeting held June 25 in New York City. They are *Drs. Louis G. Nezworski,* Eau Claire; *Ernest O. Henschel* and *John H. Huston,* Milwaukee.

NEWS FROM THE MEDICAL SCHOOLS

UW Alumni Association Officers

New officers of the University of Wisconsin Medical Alumni Association elected at the annual meeting in May are: president—Dr. Albert Martin, class of '35, a surgeon from Milwaukee; president-elect—Dr. Ben Lawton, '45, associate preceptor, Marshfield Clinic; secretary-treasurer—Dr. Richard Wasserburger, '46, associate clinical professor, Veterans Administration Hospital, Madison; directors—Dr. Joseph Stone, '35, orthopedic surgeon, Milwaukee; Dr. Einar Daniels, '34, internist, Milwaukee; Dr. Frank Weston, '24, clinical professor of medicine, University Hospitals, Madison; and Dr. Phillips Bland, '47, preceptor from Westby.

New Assistant Dean for UW

Dr. Robert Coye, assistant professor of pathology at the University of Wisconsin Medical School, assumed responsibility July 1 as assistant dean of the school. His primary duties will relate to student affairs. He will serve as chairman of the admissions committee.

Doctor Coye is the first assistant dean since Dr. O. A. Mortenson held that title. Doctor Mortenson has been promoted to associate dean which ranks behind the dean. Dr. Robert Parkin, formerly a member of the medical school faculty, was assistant to the dean before resigning to become associated with the Veterans Administration in Washington, D. C.

Doctor Coye has been with the UW Medical School since 1955 when he joined the staff of the pathology department as an instructor. His internship and residency were at Strong Memorial Hospital. Doctor Coye received his M.D. degree from the University of Rochester School of Medicine.

New Appointments at UW

Dr. John B. Wear, Jr., has been appointed instructor in the urology division of the department of surgery. He received his M.D. degree at the UW in 1954 and recently was senior resident at the University of Michigan. He will teach, lecture and carry on research. He will also aid in a revision of the urology division, of which his father is director.

Dr. Raymond W. M. Chun, a neurology trainee at the UW since July 1, 1960, has been named assistant professor of neurology and pediatrics. He received his M.D. degree in 1955 from the Georgetown University School of Medicine. Doctor Chun has held a teaching appointment at the Neurological Institute, New York City.

Dr. Charles E. Reed will head the allergy clinic in the department of medicine. He replaces Dr. Seymour Crepea who left last December to become medical and research director of the Sahuare School for Asthmatic Children, Tucson, Ariz. Doctor Reed majored in biochemistry at Harvard College and received his M.D. degree from Columbia in 1945. He served as medical officer in the Army from 1946 to 1948. He is a native of Boulder, Colo.

Dr. Richard J. Thurrell will teach and carry out research in the department of psychiatry. He has worked for the U. S. Public Health Service. Since 1958 he has been resident psychiatrist at University Hospitals in Madison and psychiatrist for Mendota State Hospital. A native of Milwaukee, Doctor Thurrell received his B.S. degree from Wisconsin in 1950 and his M.D. degree in 1954.

Dr. Carl W. Schmidt was appointed instructor in the department of anesthesiology. A native of Milwaukee, he received his M.D. degree from Wisconsin in 1947. His duties include research and departmental instruction.

A New Research Unit at UW

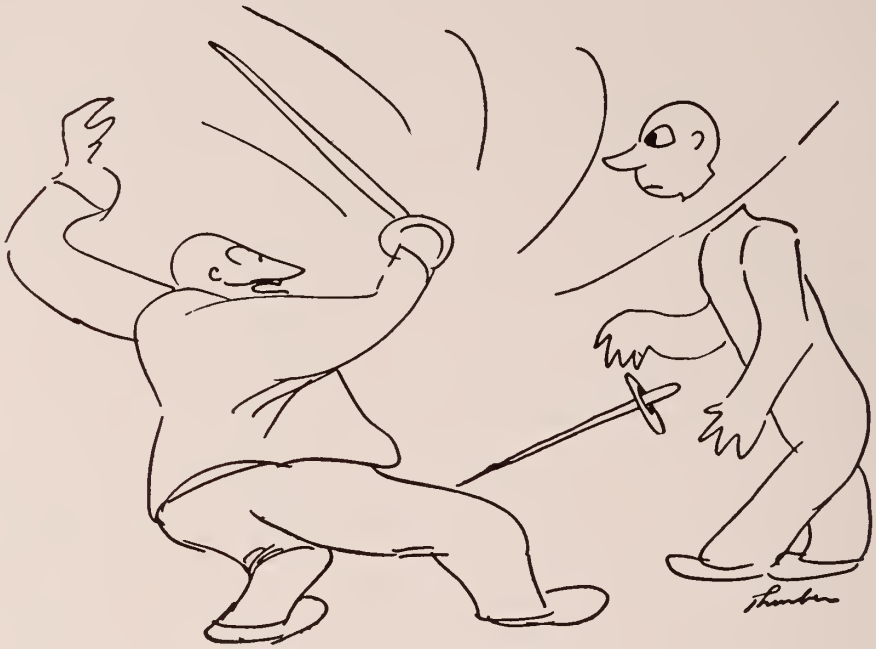
A zoonosis research group will soon be established as a new research unit of the State Hygiene Laboratory at the University of Wisconsin, according to Dr. Alfred S. Evans, director of the laboratory. Zoonosis is the study of diseases which are transmitted from animals, birds, and insects to man. The initial investigation will concern encephalitis, or "brain fever," which is carried by mosquitoes and which, under the right circumstances, can spread to man. The disease is widespread among birds and horses in Wisconsin, but has not so far infected men in this state. The project is supported by the U. S. Public Health Service.

UW Expansion in Infant Disease Research

A University of Wisconsin Medical Center program to search out a little-known disease before it causes serious mental retardation in children was extended into the state last month. The disease is phenylketonuria. The detection program is under the direction of Dr. Harry A. Waisman of the UW pediatrics department. In the first expansion, the program will begin at St. Joseph's Hospital in Milwaukee, St. Mary's Hospial in Madison, at The Monroe Clinic, and in Eau Claire and Dodge counties.

Epilepsy Research Grant to UW

A grant of $232,684, the first in a series from the National Institutes of Health totaling above $1 million for a comprehensive seven-year epilepsy research program in the University of Wisconsin Medical School, was accepted in July. This first grant will support establishment and operation of an Epilepsy Research Center. Subsequent annual grants will continue to provide for facilities, patient expense and supplies, and research expenses, including personnel. Dr. Francis M. Forster, chairman of the department of neurology, will direct the epilepsy center.



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Dr. H. J. Brehm, Racine, a general practitioner with a special interest in surgery, died December 16, 1960, at the age of 85.

Doctor Brehm was born in 1875 in Burlington and received his degree from the Milwaukee Medical College in 1901. He had practiced since that time in Racine.

A member of the Racine County Medical Society, State Medical Society of Wisconsin and American Medical Association, Doctor Brehm was a life member in the state society and a member of its Fifty Year Club.

Surviving are four children, Dr. Herbert Brehm, Dr. Richard Brehm, Mrs. Leslie Jones and Mrs. John Ryan.

Dr. John A. Halgren, a physician and surgeon at Menomonie for some 40 years, died March 22, 1961, in Eau Claire.

A native of Waseca, Minnesota, he was a 1916 graduate of the University of Minnesota Medical School. He interned at Bismarck Evangelical Hospital in Bismarck, North Dakota, from 1916 until he entered the Army Medical Corps in 1917. His service as a general surgeon brought him the Order of St. John of Jerusalem from the King of England. Discharged in 1919, Doctor Halgren returned to private practice in Bismarck, serving as vice-president of the State Board of Health for that state from 1920 to 1921. He came to Menomonie in 1922.

Doctor Halgren was a member of the Eau Claire–Dunn–Pepin County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Lillian; two sons, John of Madison, New Jersey, and William of Eau Claire.

Dr. Friedrich Eigenberger, staff pathologist at Sheboygan Memorial Hospital for 28 years, died March 27, 1961, at the age of 68.

Born in Austria March 27, 1893, Doctor Eigenberger was a 1918 graduate of the German University of Prague, Czechoslovakia. Coming to this country in 1922, Doctor Eigenberger became a charter member of the Sheboygan Clinic staff that year. He became associated with the Sheboygan Memorial Hospital in 1933, resigning from the clinic in 1951 to devote full time to his work at the hospital. From 1923 to 1927 he was instructor in pathology at Marquette University School of Medicine.

His medical affiliations included the Sheboygan County Medical Society, the State Medical Society of Wisconsin, the American Medical Association. World Medical Association, American College of Physicians, the Wisconsin and American Societies of Clinical Pathologists, and the American Board of Pathology.

Surviving are his widow, Cordelia, and a brother, Robert, of Vienna, Austria.

Dr. T. J. Aylward, Milwaukee, a general practitioner with a special interest in proctology, died April 1, 1961, at the age of 71.

Doctor Aylward was born in 1889 in Milcreek, Wisconsin. A graduate of Rush Medical College, Chicago, Illinois, in 1920, he interned at Michael Reese Hospital in that city from 1921 to 1922 and served his residency at Johnston Emergency Hospital, Milwaukee, the following year. He practiced in Milwaukee from 1923 until the time of his death.

Surviving are his widow, Rosa; a son, Thomas J. Aylward of Washington, D. C., and a daughter, Mrs. Lawrence Weaver of Arlington Heights, Illinois.

Dr. Arthur Raymond, Milwaukee, a general practitioner with a special interest in internal medicine, died April 17, 1961, at the age of 69.

Born in Prescott, Arizona, in 1891, Doctor Raymond was a 1923 graduate of Marquette University School of Medicine. He served his internship and residency at Trinity Hospital, Milwaukee, from 1923 to 1925 and practiced in Hales Corners and Winona, Minnesota, prior to establishing a practice in Milwaukee.

Doctor Raymond was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association.

Surviving is a son, Charles.

Dr. Marvin E. Solberg, a general practitioner in Elroy, died April 17, 1961, at the age of 45.

Born May 25, 1915, in Caledonia, Minnesota, Doctor Solberg received his medical degree from Marquette University School of Medicine in 1942. Following internship at St. Francis Hospital in La Crosse, he entered the Army Medical Corps and saw service in Africa, Italy, France and Germany, receiving two citations for meritorious service. Upon leaving the service in 1946, he practiced in Milwaukee and Viola, before coming to Elroy in 1958.

Doctor Solberg was a member of the Juneau County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Surviving are three daughters, Fern, Marvene and Lynda, all of Milwaukee.

Dr. Agnar T. Smedal, Stoughton, a general practitioner with a special interest in obstetrics and gynecology, died April 21, 1961, at the age of 58.

Born in McFarland, Wisconsin, in 1903, Doctor Smedal was a 1925 graduate of Rush Medical College, Chicago. He served his internship and residency at Los Angeles County General Hospital, and estab-

lished his practice in Stoughton in 1932. Doctor Smedal served with the Medical Corps in World War II in the Pacific Theater.

His medical affiliations include the Dane County Medical Society, the State Medical Society of Wisconsin, the American Medical Association and the American Association of Railroad Surgeons. He represented Dane County in the House of Delegates of the state society.

Surviving are his widow; two sons, Dr. David Smedal and Greggar Smedal, both of Stoughton; one daughter, Mrs. Roger Hyland, Stoughton; and three brothers, Dr. Erling Smedal of Mansfield, Ohio, Dr. Magnus Smedal, Boston, Massachusetts, and Dr. Harald Smedal, Palo Alto, California; and three sisters, Miss Gunna Smedal, Madison, Mrs. Leslie Kindschi, Monroe, and Mrs. Burton Quant, Madison.

Dr. Robert K. Irvine, a general practitioner at Manawa, died May 15, 1961, at the age of 63.

Born in Royalton, Wisconsin, in 1898, he received his medical degree from the University of Pennsylvania Medical School in 1922, serving an internship at the Philadelphia General Hospital and residency at Municipal Hospital, Philadelphia, from 1922 to 1924. Returning to Manawa in 1924, he joined his father, the late Dr. James W. Irvine, in practice. In 1948 he returned to Pennsylvania where he did postgraduate work at the Veterans Administration Hospital at Coatesville for two years, returning to Manawa in 1950.

Doctor Irvine was a member of the Waupaca County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, the American College of Chest Physicians, American College of Internal Medicine and American College of Obstetrics.

He is survived by his widow, Margaret.

Dr. Arthur Kovacs, a Milwaukee eye, ear, nose and throat specialist since 1925, died June 7, 1961, at the age of 69.

Born in Hungary in 1891, Doctor Kovacs received his medical degree from the Royal Hungarian University, Budapest, in 1914. Following internship and residency at the Municipal Hospital of Budapest from 1914 to 1917, he did postgraduate work in Vienna, Austria, and Chicago, before coming to Milwaukee in 1924.

Doctor Kovacs was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association and the Milwaukee Oto-Ophthalmic Society.

Surviving are his widow, Babette, and a sister, Rose, both of Milwaukee.

Dr. Erwin R. Schmidt, Madison, retired chairman of the department of surgery at the University of Wisconsin Medical School, died July 9, 1961, at his summer home at St. Joseph Island, Canada.

Born in Alma in 1890, Doctor Schmidt received his medical degree from Washington University School of Medicine, St. Louis, Missouri, in 1916. After internship at Barnes Hospital, St. Louis, from 1916–1917, he began his residency at Augustana Hospital, Chicago, Illinois, before entering the military service during World War I. Returning to Augustana Hospital in 1919, he completed his residency training in 1921 followed by postgraduate study at Maria Hospital, Stockholm, Sweden, and the University of Frankfurt, Germany. He returned to this country in 1923 and was in private practice in Billings, Montana, until 1925 when he joined the surgical staff at Augustana Hospital, Chicago.

Doctor Schmidt came to Wisconsin in 1926 to become head of the newly established department of surgery. He was chairman of the department for 35 years, retiring only eight days before his death.

His medical affiliations included membership in the Dane County Medical Society, State Medical Society of Wisconsin, American Medical Association, Central Surgical Association, American College of Surgeons, Interstate Postgraduate Medical Association, American Branch of the International Society of Surgeons, American Surgical Association, American Association for the Surgery of Trauma, Western Surgical Association, American Society of University Professors, and Wisconsin Surgical Society.

Doctor Schmidt was particularly active in the Interstate Postgraduate Medical Association of which he had been a trustee since 1950 and secretary and program chairman since 1954.

He served on the Council on Scientific Work of the State Medical Society for 10 years, and in 1949 was the recipient of the state society's Council Award, highest honor bestowed by the society. A past president of the Western Surgical Society, he was also a founder of the American Board of Surgery.

Surviving are his widow; two sons, Dr. Erwin Rudolph Schmidt, Jr., Philadelphia, Pennsylvania, and Dr. Courtland Mercer Schmidt, Ann Arbor, Michigan; and two daughters, Mrs. Robert Neuman, Cleveland, Ohio, and Mrs. Fred Carl Wolf, Jr., Oxford, England.

Dr. Ludwig A. Schoen, a retired physician who formerly practiced in Fremont, died July 14, 1961, at the age of 62.

Born in La Crosse in 1899, Doctor Schoen was a 1927 graduate of the Marquette University School of Medicine. He served his internship at St. Francis Hospital, Peoria, Illinois, and began practice in Fremont until illness forced his retirement in 1937. He was formerly a member of the Marathon County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Ann; and three daughters, Mrs. Clifford Norby, Milwaukee, Mrs. LeRoy Wolf, Rhinelander, and Miss Marjorie Schoen, Wausau.

Dr. R. P. Welbourne, Watertown physician and surgeon, died July 22, 1961, at the age of 47.

Born in West Allis in 1914, Doctor Welbourne was a 1942 graduate of the University of Wisconsin Medical School. Following internship at Research Hospital, Kansas City, Missouri, from 1942 to 1943, he served in the Army Medical Corps until 1946 when he returned to Wisconsin to take his residency at Milwaukee Hospital, which he completed in 1949. He established his practice of surgery in Watertown that year.

Doctor Welbourne was a member of the Jefferson County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, the Wisconsin Surgical Society, and the American Association of Abdominal Surgeons, a Fellow of the American College of Surgeons and a Diplomate of the American Board of Surgery. He served as chairman of the Committee on Cancer of the state society, was past president of the Wisconsin Division, American Cancer Society, and also a member of its board of directors. Active in the Wisconsin Medical Alumni Association, he was chairman of the William S. Middleton Library Fund.

Surviving are his widow, Ruth; a daughter and four sons.

Dr. Charles O. Thienhaus, Milwaukee, a general practitioner with special interest in abdominal surgery, died July 22, 1961, at the age of 92.

Born in Germany in 1868, Doctor Thienhaus received his medical degree from Berlin University, Berlin, Germany, in 1896 and served one year as surgical assistant at the Von Bergmann Surgical Clinic and three months at the Von Olshausen Gynecological Clinic in Berlin.

Doctor Thienhaus was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Emmy; two daughters, Mrs. Otto Hubbard, Traverse City, Michigan, and Mrs. Anna McTavish, Detroit, Michigan; and one son, Harold, of Long Beach, California.

Dr. Lester E. McGary, pathologist at Madison General Hospital for 33 years, died July 26, 1961, in Corsicana, Texas, at the age of 67.

Doctor McGary was born in 1892 in Norwalk, Wisconsin. A veteran of World War I, his experiences as a hospital corpsman resulted in his enrollment in the Tulane University Medical School where he received his medical degree in 1924. He became pathologist at Madison General Hospital, where he practiced until his retirement in 1957. Honored by his colleagues in 1959, a fund was established in his name to provide lecturers for medical staff meetings at the hospital. During his years in Madison, Doctor McGary established the first school for medical technicians in that city, and set up the city's first laboratory service for allergies. He also established Madison General Hospital's first four-year residency program for pathologists.

His medical affiliations include the Dane County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, the Wisconsin Society of Pathologists, the American Board of Pathology, the American College of Pathologists, the American Society of Clinical Pathologists and the Society of Geriatrics.

Surviving are his widow; two sons, Dr. Lester E. McGary, Jr., Corsicana, and Dr. Richard McGary, Madison; and one daughter, Maj. Virginia McGary, stationed in Texas.

Dr. James Rowan, Milwaukee, was killed in an automobile accident July 28, 1961, near Rhinelander. He was 61 years old.

Born in Scotland in 1900, Doctor Rowan was a 1925 graduate of Marquette University School of Medicine. Following internship at Evangelical Deaconess Hospital in Milwaukee, he established private practice in that city. From 1945 to 1946, he undertook postgraduate work in ophthalmology at the University of Pennsylvania Medical School, returning to Milwaukee to continue his practice upon completion.

Doctor Rowan was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association.

Surviving are his widow, Edwena, and four daughters.

Dr. John P. Koehler, health commissioner for the City of Milwaukee from 1925 to 1940, died at his home near West Bend August 3, 1961, at the age of 81.

Born in Russia of German parentage, Doctor Koehler came to this country in 1886. A 1911 graduate of the University of Marquette School of Medicine, he was in general practice in Milwaukee from 1911 to 1918 when he became deputy commissioner of public health for the city, and was appointed commissioner in 1925. He resigned in 1940 to be a candidate for the United States Senate and was in industrial medicine from 1942 to 1945, retiring in that year. In 1944 and 1948, he was a delegate to the Republican National Convention.

He was a member of the Milwaukee County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He became a member of the state society's Fifty Year Club in May of this year.

Surviving are his widow, Mabel, and one son, John P. Koehler, Jr., of Bayside.

Dr. Otto S. Blum, St. Petersburg, Florida, a former Wisconsin physician, died August 9, 1961, at the age of 55.

Born in Monticello, Wisconsin, in 1905, he received his medical degree from the University of Wisconsin Medical School in 1929. After residency at the University Hospital in Omaha, Nebraska, he practiced in Monticello and Albany, Wisconsin, from 1930 to 1939. After postgraduate training in eye, ear, nose and throat he served in the Armed Forces during World War II and then practiced in Waverly, Iowa,

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OBITUARIES *continued*

coming to Monroe, Wisconsin, in 1950. In 1954 he left Wisconsin, moving to Miami Beach, Florida, where he established a practice in his specialty.

Dr. Anthony E. Coletti, assistant superintendent at Mendota State Hospital, died August 14, 1961, at the age of 53.

Born in Cumberland, Wyoming, in 1908, Doctor Coletti was a graduate of the University of Louisville Medical School, Louisville, Kentucky, in 1933. Following a two-year internship at Louisville City Hospital, he entered private practice and from 1938 to 1941 served as psychiatrist in state institutions in Nebraska and Kentucky. From 1941 to 1945 Doctor Coletti was in the armed forces, serving as chief of the neuropsychiatric section at Camp San Louis Obispo, California. From 1946 until 1958, he served in various positions in state hospitals in Kentucky, Nebraska, Wisconsin and South Dakota, coming to Mendota State Hospital in 1958 as chief of male service. In 1960 he became assistant superintendent at the hospital.

Doctor Colletti was a member of the Dane County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Surviving are his widow, Mary, and one son.

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See pp. 77–78 of this issue.

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RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by written examination by the State Board of Medical Examiners at a meeting in Madison:

January 12, 1960	*School of Graduation*	*Year*	*City*
Brennan, W. M.	Marquette University	1959	Milwaukee
Wojcechowskyj, S.	Heidelberg University	1952	Milwaukee
July 12, 1960			
Becker, G. A.	Marquette University	1960	Milwaukee
Brown, R. C.	Marquette University	1960	Milwaukee
Clark, P. J.	Marquette University	1960	Dayton, O.
Fleck, R.	University of Innsbruck	1957	Madison
Geenen, J. E.	Marquette University	1960	Freedom
Idriss, F. S.	University of Beirut	1953	Chicago, Ill.
Klumper, W.	University of Bonn	1952	Madison
Logic, J. R.	Marquette University	1960	Milwaukee
Maloney, J. D.	University of Toronto	1959	Madison
McCarty, J. P.	Marquette University	1959	Silver Spring, Md.
Melms, F. A.	University of Wisconsin	1959	New York, N. Y.
Rapkin, M. A.	University of Wisconsin	1960	Madison
Schoenwetter, W.	University of Wisconsin	1959	Minneapolis, Minn.
Teich, J. C.	Marquette University	1957	Washington, D. C.
Zeller, J. R.	Marquette University	1959	New York, N. Y.
January 10, 1961			
Felton, O. L.	University of Wisconsin	1960	Sheboygan
Goerke, R. F.	Marquette University	1960	Milwaukee
Gohdes, P. N.	University of Wisconsin	1960	Rockford, Ill.
Hoyer, J. K.	University of Wisconsin	1960	Duluth, Minn.
Hughes, R. C.	University of Wisconsin	1960	Madison
Klasinski, C. A.	Loyola University	1960	Wautoma
Kleiman, M. M. W.	University of Manitoba	1956	Milwaukee
Klomberg, G. H.	Marquette University	1960	Horicon
Kloppedal, E. A.	University of Wisconsin	1960	Madison
Lameka, P.	Marquette University	1960	Milwaukee
Lasser, A. E.	University of Wisconsin	1960	Milwaukee
McLeod, P. A.	University of Wisconsin	1960	Madison
Meyer, G. A.	University of Wisconsin	1960	Madison
Milson, S. E.	Marquette University	1960	Green Bay
Moon, R. E.	University of Wisconsin	1960	Madison
Mueller, J. M.	Northwestern University	1960	Wausau
Mullooly, J. P.	Marquette University	1960	Milwaukee
Natter, C. E.	University of Wisconsin	1960	Long Beach, Calif.
Natter, J. R.	University of Wisconsin	1960	Long Beach, Calif.
Oechler, H. W.	University of Wisconsin	1960	Kenosha
Porter, P. H.	Cornell University	1960	Madison
Salan, J. R.	Northwestern University	1960	Waupaca
Sievert, R. A.	University of Wisconsin	1960	La Crosse
Stephl, P.	University of Wisconsin	1959	Madison
Vandervort, G. E.	University of Wisconsin	1960	Madison
Weber, W. G.	Marquette University	1960	Youngstown, O.
July 12, 1961			
Albrecht, P. G.	University of Minnesota	1960	Sparta
Bell, James E.	Howard University	1957	Milwaukee
Brown, H. S.	Indiana University	1958	Rolling Prairie, Ind.
Calloway, N. O.	University of Illinois	1943	Adams
Capone, C.	University of Naples	1953	Winnebago
Cushman, S. M.	Northwestern University	1956	Racine
Davidson, P. L.	New York College of P&S	1955	Madison
Dick, H. J.	Syracuse University	1938	Sheboygan
Ernest, F. III	Jefferson Medical College	1943	Madison
Elson, M. W.	Ohio State University	1949	West Allis
Fiedler, H. W.	New York University	1957	Milwaukee
Gore, D. R.	University of Illinois	1961	Milwaukee
Herrmann, A. A.	Marquette University	1960	Racine
Jacobs, P. A.	State University—New York	1954	Milwaukee
Johansen, G. W.	University of Illinois	1956	Wauwatosa
Johnson, K. O.	Northwestern University	1958	Milwaukee
Jonas, E. R.	University of Minnesota	1960	Ellsworth
Jones, D. R.	Creighton University	1954	Rochester, Minn.

July 12, 1961	*School of Graduation*	*Year*	*City*
Knaff, L. J.	Stritch School of Medicine	1955	La Crosse
Kushner, R. S.	State University—New York	1960	Madison
Lofdahl, S. A.	Northwestern University	1960	Ripon
Mattingly, R. F.	Cornell University	1953	Milwaukee
McAllister, R. V.	Creighton University	1945	Wood
McDevitt, W. P.	University of Iowa	1959	Milwaukee
McNeal, W. E.	College of Medical Evang.	1960	Green Bay
Parker, C. D.	University of Texas	1960	Madison
Powell, J. E.	Indiana University	1960	Chetek
Reed, C. S.	Columbia University	1945	Madison
Robbins, D.	Geneva, Switzerland	1958	Madison
Roller, M. C.	Indiana University	1960	Chetek
Runge, R. M.	University of Louisville	1956	Madison
Sautter, R. D.	University of Nebraska	1953	Marshfield
Scribner, L. F.	Wayne University	1954	Monroe
Sender, N.	University of Sheffield	1955	Milwaukee
Simon, T. R.	St. Louis University	1945	Milwaukee
Soergel, K. H.	Erlangen, Germany	1954	Milwaukee
Stewart, O. K.	Georgetown University	1952	Sheboygan
Terrano, J. V.	Chicago Medical School	1954	Plum City
Thomas, H. R.	University of Iowa	1960	Eau Claire
Trees, H.	University of Heidelberg	1948	Coloma
Wirtanen, G. W.	University of Florida	1960	Madison
Wright, W. E.	University of Nebraska	1925	Mondovi
Yu, Shao-Chi	Canton—China	1936	Winnebago

The following physicians were granted licenses by oral reciprocity examination by the State Board of Medical Examiners at a meeting in Madison:

October 23, 1959	*School of Graduation*	*Year*	*City*
Markovitch, M. T.	Indiana University	1957	Highland Park, Ill.
January 13, 1960			
Falcone, A. B.	Temple University	1947	Milwaukee
April 22, 1960			
Aurand, G. D.	University of Illinois	1959	Chicago, Ill.
July 13, 1960			
Carey, L. C.	Ohio State University	1959	Milwaukee
Hawkins, L. K.	University of Penn.	1955	Madison
Manley, J. C.	St. Louis University	1959	Milwaukee
Nevels, Z. J.	Howard University	1958	Milwaukee
O'Brien, R. E.	Ohio State University	1956	Madison
Newill, D. S.	Eclectic Medical College	1951	Connellsville, Pa.
Randall, H. J.	University of Iowa	1959	Madison
Rinder, R. S.	Marquette University	1959	Milwaukee
October 14, 1960			
Baumann, R. R.	Johns Hopkins	1954	Monroe
Chosy, L. W.	Ohio State University	1959	Madison
Cote, R. A.	University of Montreal	1955	Milwaukee
Fruth, R. B.	Albany Medical College	1949	Wood
Gott, V. L.	Yale Medical School	1953	Madison
Kreutzer, E. W.	University of Oregon	1942	Madison
Miller, M.	University of New York	1959	Madison
Smithey, P. J.	Howard University	1950	Milwaukee
Yount, L. J.	Ohio State University	1959	Milwaukee
January 11, 1961			
Litton, E. W.	Medizinisch Academia	1952	Madison
April 14, 1961			
Buchanan, K. E.	George Washington University	1960	Little Chute
Warrick, J. D.	University of Wisconsin	1951	Lompoc, Calif.

MEDICAL MEETINGS—POSTGRADUATE COURSES

UW Half-Day Courses for GPs

The following are forthcoming half-day courses at the University of Wisconsin Medical Center.

"F.U.O."—The Unexplained Fever

October 5, 1961

Dr. J. L. Sims, Chairman

A discussion of the problems and mechanisms involved in the production of fever of obscure origins, and of the means employed and directions taken in an attempt to discover its cause. A general review of the problem and of the pathologic physiology of fever will be followed by a systematic discussion of possible sources. A final question and answer period and summarization will bring the various aspects into focus.

1:30 to 2:00	The Problem, and its Pathologic Physiology—Dr. John Curtis, Chief of Medical Service, U. S., VA Hospital, Madison
2:00 to 2:20	The Respiratory Tract—Dr. Helen Dickie, Professor of Medicine
2:20 to 2:40	The Gastrointestinal Tract—Dr. J. LeRoy Sims, Professor of Medicine
2:40 to 3:00	Blood Diseases and Lymphomas—Dr. Dallas Clatanoff, Assistant Professor of Medicine
3:00 to 3.20	Intermission
3:20 to 3:40	The Urinary Tract—Dr. Arvin Weinstein, Assistant Professor of Medicine
3:40 to 4:00	The Collagen Diseases and Histiocytoses—Dr. Robert Schilling, Associate Professor of Medicine
4:00 to 4:20	"Idiopathic," Psychogenic and Periodic Fevers—Dr. J. D. Kabler, Assistant Professor of Medicine
4:20 to 5:00	Discussion Period and Summary—Dr. John Curtis

Frequent Surgical Problems Occurring in General Practice

November 2, 1961

Dr. J. W. Gale, Chairman

This course is planned, not for those practicing in special fields of medicine, but for those engaged in broad fields of general practice. By lecture and demonstration—using moulages and actual demonstrations when possible—the practical treatment of a variety of injuries and other surgical conditions will be discussed; information of a practical nature will be reviewed.

1:30 to 2:00	Head Injuries—Dr. Manucher Javid, Associate Professor of Surgery (Neurosurgery)
1:55 to 2:15	Eye Injuries—Dr. Peter Duehr, Clinical Professor of Surgery (Ophthalmology)
2:20 to 2:40	Chest Injuries—Dr. John Pellett, Assistant Professor of Surgery
3:00 to 3:20	Fractures of the Hip—Dr. Robert E. Burns, Professor of Surgery (Orthopedic)
3:25 to 3:45	Acute Vascular Embolic Phenomena—Dr. William Young, Professor of Surgery (Cardiovascular)
3:50 to 4:10	Face Injuries—Dr. Gordon Davenport, Clinical Assistant Professor of Surgery (Plastic)
4:15 to 4:35	Acute Gastrointestinal Bleeding—Dr. Kenneth Lemmer, Professor of Surgery

Other half-day courses for the general practitioners include: DERMATOLOGY on Jan. 4, 1962; PEDIATRICS on Feb. 1, 1962; ORTHOPEDICS on Mar. 8, 1962; GYNECOLOGY–OBSTETRICS on Apr. 12, 1962; and THERAPEUTICS on May 3, 1962.

Registration fee for each course is $10. Each session has been awarded 4 hours of Category I credit by the American Academy of General Practice.

UW Postgraduate Courses

"Psychiatry for the General Physician" will be presented Oct. 13–14 at the University of Wisconsin Medical Center under direction of Dr. Robert Roessler, Chairman of Department of Psychiatry, and Director of Psychiatric Institute. This course will present emotional problems frequently seen in the general practice of medicine. The diagnosis, treatment and means of understanding these patients will be discussed. Emphasis will be on practical rather than theoretical views of these problems.

"Rehabilitation of Patients with Injuries of the Spinal Cord" will be presented Nov. 16–18 under direction of Dr. Arthur A. Siebens, Director of Respiratory and Rehabilitation Center. This course is designed to review the care of the increasing number of patients who survive traumatic injury to the spinal cord. Current concepts of the neurophysiological basis of voluntary motion and muscle tone will be presented, together with principles of acute and chronic care. University faculty and guest participants will lecture and lead discussion groups on present techniques of restoration with functional bracing and orthopedic surgery. Other topics include the effects of such lesions on specific organ systems and the psychosocial aspects of rehabilitating these patients.

Further information may be obtained from Coordinator, Postgraduate Program in Medical Education, The Wisconsin Center, 702 Langdon Street, Madison 6, Wisconsin.

WISCONSIN CALENDAR COMING EVENTS

1961

Sept. 27: Circuit teaching program, Marinette-Menominee, Mich.

Sept. 28: Circuit teaching program, Waupaca.

Sept. 28–30: UW postgraduate course, Anesthesiology, Dr. O. S. Orth, chrm., University Hospitals, Madison.

Sept. 30: Fall cancer scrimmage, UW Medical Center, Madison.

Oct. 4: Circuit teaching program, Ashland.

Oct. 5: Circuit teaching program, Rhinelander.

Oct. 5: Marquette-Jackson Clinic postgraduate course, Madison.

Oct. 5: UW half-day course for GPs on "F.U.O.—The Unexplained Fever," Madison.

Oct. 13–14: UW postgraduate course, Psychiatry, Dr. R. Roessler, chrm., Wisconsin Center Building, Madison.

Oct. 19–20: Milwaukee Medical Conference, Milwaukee County Hospital.

Oct. 23–24: Scientific session, American Cancer Society, New York City.

Nov. 2: UW half-day course for GPs on "Frequent Surgical Problems Occurring in General Practice," Madison.

Nov. 13–17: Annual meeting, American Public Health Association, Detroit, Mich.

Nov. 16–18: UW postgraduate course, Rehabilitation of Patients with Injuries of the Spinal Cord, Dr. A. Siebens, chrm., Wisconsin Center Building, Madison.

Nov. 28–Dec. 1: AMA Clinical Meeting, Denver, Colorado.

1962

Apr. 5–7: UW postgraduate course, Genetics in Pediatrics, Drs. J. Crow and N. Smith, co-chrm., Wisconsin Center Building, Madison.

Apr. 26–28: UW postgraduate course, Psychosomatic Medicine, Dr. David Graham, chrm., Wisconsin Center Building, Madison.

May 8–10: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 10–11: UW postgraduate course, Orthopedic Surgery, Dr. H. Wirka, chrm., Wisconsin Center Building, Madison.

May 17–19: UW postgraduate course, Anatomy, Physiology and Pathology of the Holocrine, Apocrine and Eccrine Glands, Dr. S. Johnson, chrm., Wisconsin Center Building, Madison.

June 25–29: AMA Annual Meeting, Chicago, Illinois.

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California.

MEDICAL MEETINGS *continued*

American Rhinologic Society Meeting

The 7th annual meeting of the American Rhinologic Society will be held in the Belmont Hotel, Chicago, Oct. 7. All physicians are invited; there is no registration fee. For further information, write to Dr. Robert M. Hansen, secretary, 2210 Lloyd Center, Portland 12, Ore.

Thirty-First
MARQUETTE–JACKSON CLINIC
Postgraduate Program

LORAINE HOTEL, MADISON
THURSDAY, OCTOBER 5, 1961

1:30 REGISTRATION

2:00 WELCOME, *Arnold S. Jackson, M.D.*

2:10 VAGINAL BLEEDING IN CHILDREN, *Barbara A. Brew, M.D.*, Department of Obstetrics and Gynecology, Jackson Clinic, Madison

2:30 CHRONIC ANEMIA, *Bertram H. Dessel, M.D.*, Department of Internal Medicine, Marquette University School of Medicine, Milwaukee

2:50 MULTIPLE MYELOMA—DIFFICULTIES IN DIAGNOSIS, *Thomas D. Ghrist, M.D.*, Department of Internal Medicine, Jackson Clinic

3:10 INTERMISSION

3:30 MASSIVE GASTROINTESTINAL HEMORRHAGE, *Miles B. Smith, M.D.*, Department of Internal Medicine, Marquette

3:50 TREATMENT OF ASCITES AND EDEMA WITH THIAZIDE AND ALDOSTERONE ANTAGONISTS, *Donald A. Roth, M.D.*, Department of Internal Medicine, Marquette

4:10 CINDERELLA SURGERY, *Vaughn E. Demergian, M.D.*, Department of Plastic Surgery, Jackson Clinic

4:30 PANEL—MANAGEMENT OF ATHEROSCLEROSIS AND ITS COMPLICATIONS; A CRITICAL APPRAISAL OF CURRENT METHODS, *Hubert C. Ashman, M.D.*, moderator, *John H. Morledge, M.D.*, *William B. Parsons, Jr., M.D.*, Department of Internal Medicine, Jackson Clinic

5:30 SOCIAL HOUR

6:00 DINNER

Conference on Measles Immunization

An international conference on measles immunization will be held November 7 through 9 at the National Institutes of Health in Bethesda, Maryland.

The conference is under the joint sponsorship of the University of Colorado, the National Institute of Allergy and Infectious Diseases, and the Division of Biologics Standards.

The three-day meeting will be divided into several sessions covering the worldwide epidemiologic aspects of the disease; properties of attenuated measles virus strains; field data on the use of live attenuated vaccines; problems of production of the vaccines and biologic control; and the future of measles immunization.

Independent investigators from university and pharmaceutical laboratories, some of whom have conducted field trials with experimental vaccines in this country, and representatives from other nations where measles is a problem, have been invited to attend the November conference.

Course in Postgraduate Gastroenterology

The American College of Gastroenterology announces that its Annual Course in Postgraduate Gastroenterology will be given at the Sheraton–Cleveland in Cleveland, Ohio, on Oct. 26, 27, and 28.

For further information and enrollment write to the American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

Course in Laryngology and Bronchoesophagology

The Department of Otolaryngology, University of Illinois College of Medicine, will conduct a postgraduate course in Laryngology and Bronchoesophagology from October 23 through November 4, under the direction of Paul H. Holinger, M.D.

Registration will be limited to fifteen physicians who will receive instruction by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

Details on Medical Congresses

Scandinavian Airlines System is making available a comprehensive calendar of overseas medical congresses and allied events during the period October 1961–December 1962. The calendar lists all known medical events in areas served by the airline.

Details can be obtained from SAS offices or by writing to A. John Harrison, secretary, Medical Travel Section, Scandinavian Airlines System, 138–02 Queens Blvd., Jamaica 35, N.Y.

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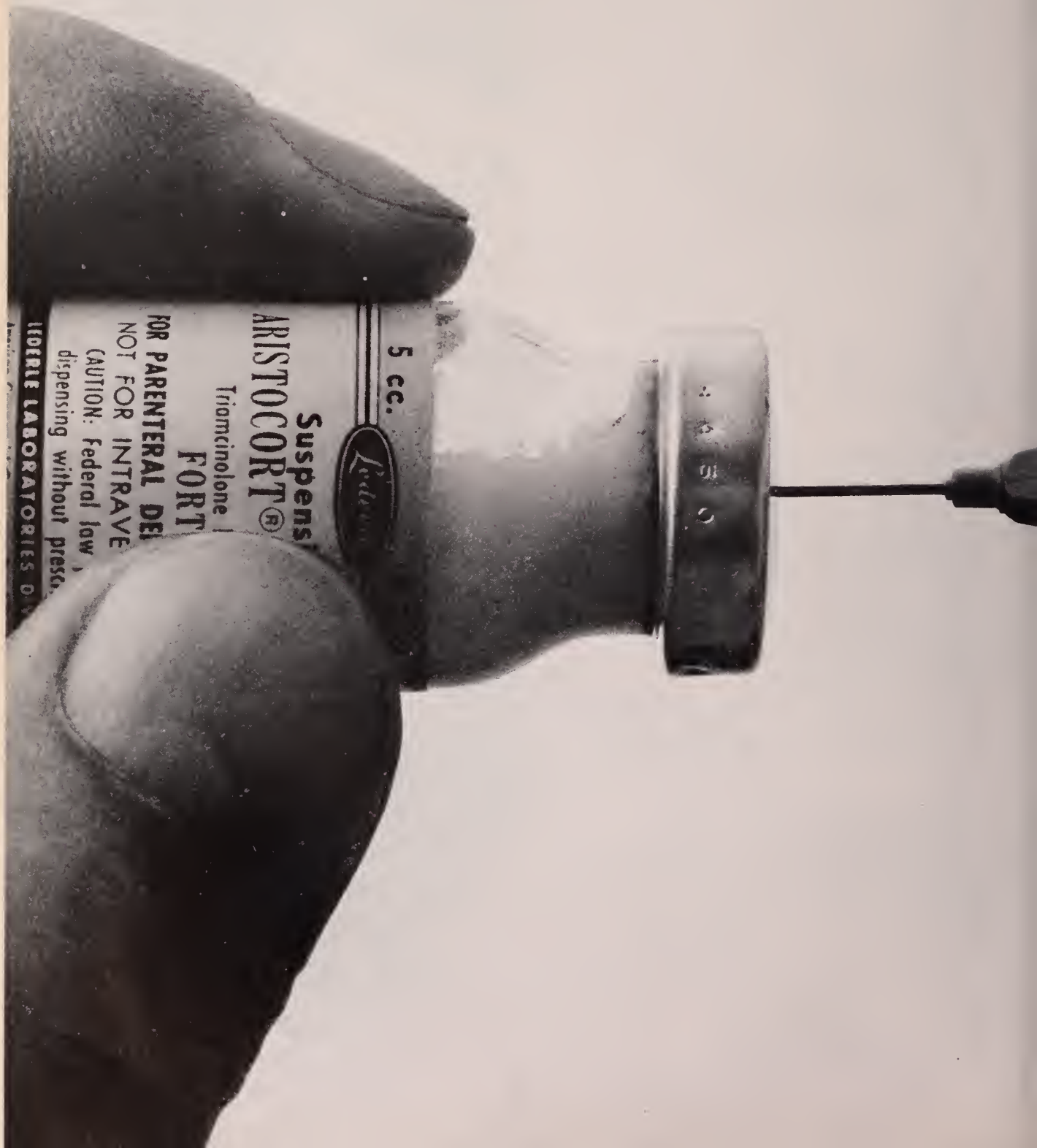

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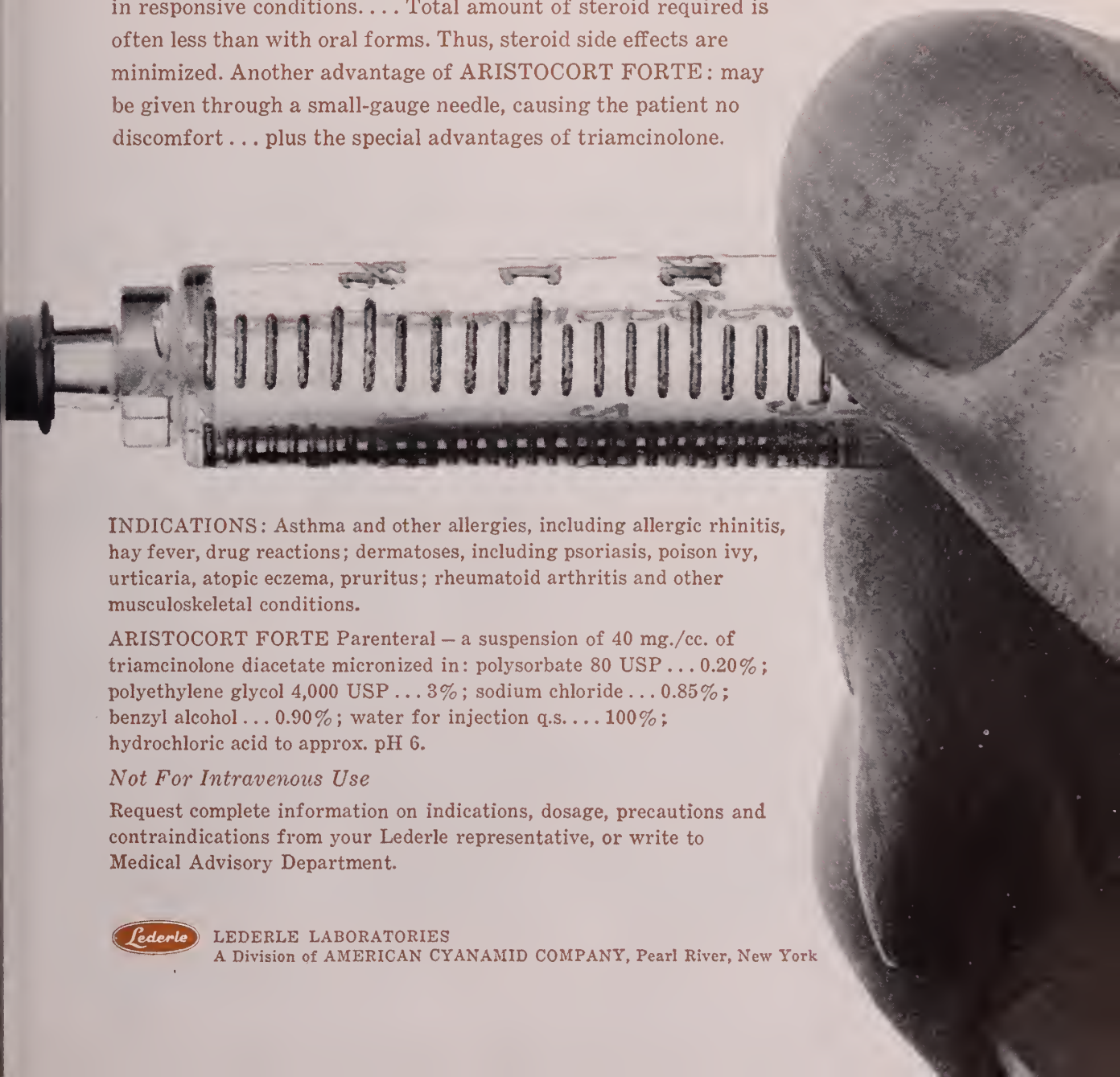

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ARISTOCORT FORTE Parenteral—a suspension of 40 mg./cc. of triamcinolone diacetate micronized in: polysorbate 80 USP . . . 0.20%; polyethylene glycol 4,000 USP . . . 3%; sodium chloride . . . 0.85%; benzyl alcohol . . . 0.90%; water for injection q.s. . . . 100%; hydrochloric acid to approx. pH 6.

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1961 MILWAUKEE MEDICAL CONFERENCE

Thursday, Friday, Saturday—October 19, 20, 21

William L. Coffey Auditorium—Milwaukee County General Hospital

GENERAL CHAIRMAN: Wilson Weisel, M.D.

Sponsored by The Medical Society of Milwaukee County, assisted in part through grants from the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin; the Wisconsin Chapter of the Arthritis and Rheumatism Foundation; and the Milwaukee Division of the American Cancer Society.

REGISTRATION OPEN TO ALL PHYSICIANS. Registration Fee: $5.00. No fee for residents, interns, students.

All That's NEW in Medicine

THURSDAY, OCTOBER 19

A.M.

8:30 Registration (continues throughout conference)

CLINICAL PHYSIOLOGY OF DISEASE, *W. W. Engstrom, M.D.*, Chairman

9:15 Clinical Pathological Physiology of Esophageal Lesions, *Howard A. Andersen, M.D.*, Rochester, Minn.

9:45 Pathophysiology of Connective Tissue Diseases, *Ivan F. Duff, M.D.*, Ann Arbor, Mich.

10:30 Clinical Pathological Physiology of Degenerative Vascular Disease, *William S. Middleton, M.D.*, Washington, D.C.

11:00 Pulmonary Pathophysiology of Hemoptysis, *Herman J. Moersch, M.D.*, Rochester, Minn.

11:30 Newer Aspects of Pulmonary Pathophysiology, *Averill A. Liebow, M.D.*, New Haven, Conn.

P.M.

12:15 Clinical Pathological Conference, *Herman J. Moersch, M.D.*, and *Averill A. Liebow, M.D.*, Participants

1:00 Lunch

NEW DEVELOPMENTS IN RADIOLOGY, *S. A. Morton, M.D.*, Chairman

2:30 New Developments in Radiologic Diagnosis, *John F. Holt, M.D.*, Ann Arbor, Mich.

3:15 Cineradiography of the Gastrointestinal Tract, *Joseph Jorgens, M.D.*, Minneapolis, Minn.

4:15 New Concepts in Radiation Therapy, *John P. Storaasli, M.D.*, Cleveland, Ohio

5:00 Current Report on the Atomic Bomb Casualty Commission Study Unit on Hiroshima, *J. W. Hollingsworth, M.D.*, West Haven, Conn.

6:30 A Night in Old Milwaukee, buffet supper (all physicians and wives invited; tickets: $7 per person; $14 per couple)

FRIDAY, OCTOBER 20

A.M.

8:30 Registration

WHAT'S NEW IN MEDICINE?, *George A. Hellmuth, M.D.*, Chairman

9:30 What's New in Allergy?, *John M. Sheldon, M.D.*, Ann Arbor, Mich.

10:15 What's New in Dermatology?, *Louis A. Brunsting, M.D.*, Rochester, Minn.

11:30 What's New in Rheumatology? Current Concepts of the Management of Connective Diseases, *Ivan F. Duff, M.D.*, Ann Arbor, Mich.

P.M.

12:15 What's New in Psychiatry?, *Avery D. Weisman, M.D.*, Boston, Mass.

1:00 Lunch

WHAT'S NEW IN MEDICINE?, *E. H. Ellison, M.D.*, Chairman

2:30 What's New in Pediatric Surgery?, *H. William Clatworthy, Jr. M.D.*, Columbus, Ohio

3:15 What's New in Reconstructive Surgery?, *J. J. Longacre, M.D.*, Cincinnati, Ohio

4:15 Question and Answer Panel, *William H. Frackelton, M.D.*, Milwaukee, Chairman. Participants: *John M. Sheldon, M.D.*, *Louis A. Brunsting, M.D.*, *Ivan F. Duff, M.D.*, *Avery D. Weisman, M.D.*, *H. William Clatworthy, Jr., M.D.*, and *J. J. Longacre, M.D.*

SATURDAY, OCTOBER 21

Marquette–UW Program: Marquette University, University of Wisconsin medical schools and medical alumni program.

continued on next page

MILWAUKEE MEDICAL CONFERENCE *continued from preceding page*

SATURDAY, OCTOBER 21

A.M.

ENDOCRINE DISEASE, *John L. Sims, M.D.*, Chairman

9:00 Problems of the Nodular Goiter, *Edwin C. Albright, M.D.*, Madison

9:20 Progress in Understanding Diabetes, *Edgar S. Gordon, M.D.*, Madison

9:40 The Adrenogenital Syndrome, *Frank C. Larson, M.D.*, Madison

10:00 Question and Answer Period

NEPHROTIC SYNDROME, *Bruno J. Peters, M.D.*, Chairman

10:30 A Pathological Concept of Glomerulonephritis, *Paul Kimmelstiel, M.D.*, Milwaukee

10:50 Clinical Manifestations of the Nephrotic Syndrome, *Donald A. Roth, M.D.*, Milwaukee

11:10 Pathological Physiology and Treatment of the Nephrotic Syndrome, *Ben I. Heller, M.D.*, Milwaukee

11:30 Question and Answer Period

ASSOCIATED ACTIVITIES

Tuesday, Oct. 17

1 p.m. **Dean's Hour**, Marquette University School of Medicine, *Henry N. Wagner, Jr., M.D.*, Department of Medicine, Johns Hopkins, Baltimore (sponsored by Alpha Omega Alpha)

6 p.m. **Milwaukee Orthopedic Club** Dinner Meeting, Milwaukee Athletic Club, "Soft Tissue Release for Hip Pain," *James R. Regan, M.D.*, Milwaukee

8 p.m. **Milwaukee Academy of Medicine** Scientific Meeting, University Club, *Henry N. Wagner, Jr., M.D.*, Baltimore, Md.

Wednesday, Oct. 18

8 a.m. **Milwaukee Orthopedic Club**, Ward Rounds, Milwaukee County General Hospital

"Hip Prosthesis in Treatment of Acute Fractures," *Frederick G. Gaenslen, M.D.*

"Bone Grafting, Comparative Studies," *Peter L. Carnesale, M.D.*

"Treatment of Acute Tibial Fractures with Open Reduction," *John O' D. McCabe, M.D.*

12 noon Luncheon, Milwaukee Children's Hospital

"Influences on the Development of Scoliotic Curves," *Walter P. Blount, M.D.*

"Operational Approaches to Problems of Cerebral Palsy," *Raymond C. Waisman, M.D.*

Friday, Oct. 20, thru Sunday, Oct. 22

Joint Meeting, Wisconsin Society of Pathologists and Wisconsin Society of Medical Technologists

Friday, Oct. 20, 1–5 p.m.—Pre-Convention Seminar

"Ultra Micro Methods," *Edwin M. Knights, Jr., M.D.*, Flint, Mich. (to be held at Marquette U. Sch. of Med.)

"Radioisotopes in the Diagnosis of Hematologic Disease," *David LaFond, M.D.*, Milwaukee (to be held at Milwaukee Hospital)

Saturday, Oct. 21, 9–11:30 a.m. (to be held at Ambassador Hotel)

"Quality Control in the Routine Laboratory (other than chemistry)," *Jo Anne Wienke, M.T.* (A.S.C.P.), Milwaukee

"The Use of Photography in Microbiology," *James Collard, M.T.* (A.S.C.P.), Marshfield

"Porphyrin Excretions After Telepaque Ingestion," *Robert Dimel*, Marshfield

"The Value of Routine Serum Iron and Iron Binding Capacity," *William J. Blake, M.D.*, Milwaukee

"Development of Ultra Micro Methods in the Clinical Laboratory," *Edwin M. Knights, Jr., M.D.*, Flint, Mich.

Saturday, Oct. 21, 1:30 p.m.—Tissue Seminar for physicians (to be held at Marquette U. Sch. of Med.)

LADIES' PROGRAM

Thursday, Oct. 19

6:30 p.m. "A Night in Old Milwaukee," Wisconsin Club

8:30 p.m. (optional) Milwaukee Symphony Orchestra, Pabst Theatre. Pianist: Claudette Sorel. Conductor: Harry John Brown

Friday, Oct. 20

12:30 p.m. Luncheon, Milwaukee Athletic Club. Guest Speaker: Harry John Brown, Conductor, Milwaukee Symphony Orchestra

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Surgical Technic, Two Weeks, November 6
Surgery of Colon & Rectum, One Week, November 27
Gallbladder Surgery, Three Days, October 9
Surgery of Hernia, Three Days, October 12
Basic Principles in General Surgery, Two Weeks, October 16
Surgical Board Review, Part I, Two Weeks, November 6
Surgical Board Review, Part II, Two Weeks, November 27
General Surgery, One Week, October 30
Hard Surgery, One Week, October 9
Gynecology, Office & Operative, One Week, October 23
Vaginal Approach to Pelvic Surgery, One Week, October 2
Obstetrics, General & Surgical, Two Weeks, October 9
Basic Electrocardiography, One Week, October 2
Internal Medicine, Two Weeks, October 16
Fractures & Traumatic Surgery, Two Weeks, October 23
Thoracic Surgery, One Week, October 16
Advances in Surgery, One Week, October 23
Advances in Medicine, One Week, November 27
Clinical Uses of Radioisotopes, Two Weeks, October 2
Blood Vessel Surgery, One Week, November 13
Urology, Two Weeks, October 23

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MEDICAL MEETINGS *continued*

North Shore Hospital Lecture

The opening lecture in the North Shore Hospital Seminars of 1961–1962 on "Mental Hygiene" will be held at the hospital, Winnetka, Ill., on Wednesday, Oct. 11, at 8 p.m. The principal speaker will be Dr. David McK. Rioch, Director Neuropsychiatry Division, Walter Reed Army Institute of Research, Washington, D. C., who will discuss "The Challenge of Survival in the Atomic Age."

American Cancer Society Program

"The Physician and the Total Care of the Cancer Patient" will be the theme for the scientific program of the American Cancer Society meeting Oct. 23–24 at the Biltmore Hotel, New York City. Topics to be discussed include: "Decisions in the Early Care of the Cancer Patient," "Counselling the Cancer Patient," "What the Cancer Patient Should be Told About His Diagnosis and Prognosis," "Care of the Advanced Cancer Patient," and "Society's Role in Care for the Cancer Patient."

Three Wisconsin physicians will participate in the program: Dr. Anthony R. Curreri, University of Wisconsin Medical School, Madison; Dr. Jay J. Jacoby and Dr. John S. Hirschboeck, Marquette University School of Medicine, Milwaukee.

Chest Physicians to Meet in Denver

The American College of Chest Physicians will hold its annual Interim Session at the Brown Palace Hotel in Denver, Colo., Nov. 25–26. A program may be obtained by writing the Executive Offices of the College at 112 East Chestnut Street, Chicago, Ill.

Medical Library Association Meeting

The meeting of the Midwest Regional Group of the Medical Library Association will be held in Rochester, Minn., on Oct. 27 and 28. Mr. Thomas E. Keys, Librarian, Mayo Clinic, is chairman of the local committee. Any inquiries about the meeting should be addressed to him at the Mayo Clinic.

Assembly in Endocrinology and Metabolism

The Thirteenth Postgraduate Assembly in Endocrinology and Metabolism, under the co-sponsorship of The Endocrine Society and The National Institutes of Health, will be held October 2–6 at Bethesda, Md.

A comprehensive review of clinical endocrine problems and current research activity in these areas will be presented. For further information, write to: Dr. Roy Hertz, National Institutes of Health, Building 10, Bethesda 14, Md. The fee will be $100 for physicians, with a reduction to $30 for Residents and Fellows. Enrollment limited to 100.

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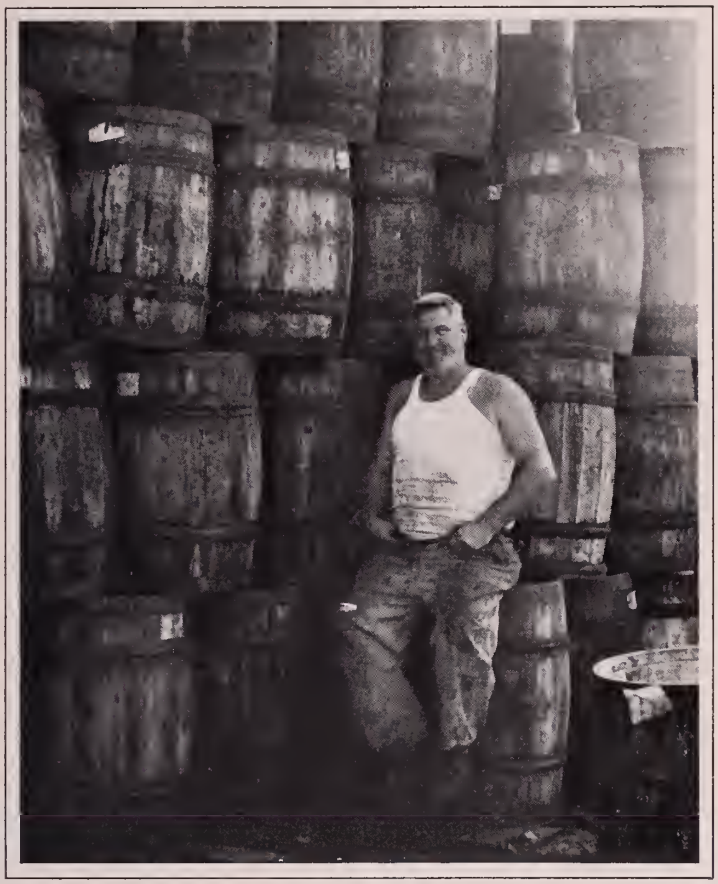

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MEDICAL MEETINGS *continued*

Circuit Teaching Programs

The following are forthcoming circuit teaching programs to be presented under auspices of the Charitable, Educational and Scientific Foundation of the State Medical Society in cooperation with the Wisconsin Academy of General Practice, Wisconsin State Board of Health, Wisconsin Heart Association, Wisconsin Division of American Cancer Society, Wisconsin Anti-Tuberculosis Association and the Postgraduate Program of Merck Sharp & Dohme.

SEPT. 27: MARINETTE–MENOMINEE
St. Joseph Lloyd Hospital, Menominee
SEPT. 28: WAUPACA
Waupaca Country Club
2:00–5:30 P.M.

Edgar S. Gordon, M.D., professor of medicine, UW Medical School, "New Developments in Diagnosis and Treatment of Diabetes" and "Present Status of the Pituitary Hormones."

George A. Hellmuth, M.D., associate professor of medicine, Marquette Univ. School of Medicine, "Modern Drug Therapy in the Management of Serious Arrhythmias" and "New Concepts of Digitalis Toxicity."

Robert T. McCarty, M.D., associate clinical professor of surgery, Marquette Univ. School of Medicine, "CA of the Colon—What Can the Generalist Do About It?" and "Office Proctology."

OCT. 4: ASHLAND
Marine Club
OCT. 5: RHINELANDER
St. Mary's Hospital
2:00–5:30 P.M.

Thomas V. Geppert, M.D., assistant clinical professor of pediatrics, UW Medical School, "Jaundice in Childhood" and "Nephritis."

Ben R. Lawton, M.D., thoracic surgeon, Marshfield Clinic, "'Do It Yourself' Treatment of Chest Injuries" and "Surgical Treatment of Strokes."

Yoshiro Tairo, M.D., pathologist, Deaconess Hospital, Milwaukee, "New Tests of Interest and Concern to the Generalist" and "Laboratory Aids in the Diagnosis of Common Auto-Immune Diseases."

NOV. 1: DODGEVILLE
St. Joseph's Hospital
NOV. 2: BEAVER DAM
St. Joseph's Hospital
2:00–5:30 P.M.

David J. Carlson, M.D., associate professor of pathology, Marquette Univ. School of Medicine, "New Tests of Interest and Concern to the Generalist" and "The Changing Character of Carcinoid Tumors."

John H. Isaacs, M.D., assistant clinical professor of obstetrics and gynecology, Stritch School of Medicine, Loyola University, Chicago, "Evaluation of Papanicolaou Smears" and "Dysfunctional Uterine Bleeding."

Hartwell Thompson, M.D., assistant professor of neurology, UW Medical School, "Parkinsonism . . . A Common Problem Encountered in General Practice" and "What Can the Family Physician Do in Treating the Patient with Multiple Sclerosis?".

Fee: $4.00 per clinic. A.A.G.P. Credit: Three hours of Category I for those in attendance. Advance registration necessary. Write to State Medical Society, Box 1109, Madison 1, Wisconsin.

CIRCUIT TEACHING PROGRAMS

1961
Sept. 27: St. Joseph's Hosp., Menominee, Mich.
Sept. 28: Waupaca Country Club, Waupaca
Oct. 3: Marine Club, Ashland
Oct. 4: St. Mary's Hosp., Rhinelander
Nov. 1: St. Joseph's Hosp., Dodgeville
Nov. 2: St. Joseph's Hosp., Beaver Dam

1962
Jan. 31: Vernon Mem. Hosp., Viroqua
Feb. 1: Elks Club, Portage
Feb. 21: Village Inn, Delavan
Feb. 22: American Legion Club, Oconomowoc

For further details, write State Medical Society. Box 1109, Madison 1, Wis.

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VOL. 60, NO. 10—OCTOBER 1961

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COUNTY SOCIETY PROCEEDINGS

CHIPPEWA

Members of the Chippewa County Medical Society heard *Dr. Watson B. Larkin,* Marshfield, talk on "Surgical Treatment of Deafness" at a meeting September 5 in Stanley. Doctor Larkin is a practicing otolaryngologist at the Marshfield Clinic. His appearance was sponsored by the CES Foundation of the State Medical Society under grant by Merck Sharp and Dohme.

Physicians whose names appear in italic are members of the State Medical Society.

During the business session the group discussed the Professional Services Corporation Act. A discussion was also held on the State Board of Health's program for periodic chest x-rays and blood pressure readings.

RICHLAND

Dr. R. E. Housner's summer cottage at Orion was the site of the August 3 meeting of the Richland County Medical Society. Guest speaker was *Dr. Clemens Kwapy* of Milwaukee. His topic was "Ophthalmology in India."

SPECIALTY SOCIETY PROCEEDINGS

Milwaukee Oto-Ophthalmic Society

New officers for the 1961–1962 year of the Milwaukee Oto-Ophthalmic Society are: president—*Dr. George J. Roncke;* vice-president—*Dr. Charles J. Finn;* and secretary-treasurer—*Dr. Arvid G. Holm.*

The new year's program is as follows:

Nov. 28—Speaker, Eugene Derlecki, M.D., Chicago, Ill. Topic, Conservative Management of Stapes.

Jan. 23—Program in charge of the eye, ear, nose, and throat residents at Veterans Administration Hospital, Wood, and Milwaukee County Hospital.

Feb. 6—Speaker, *Jules Levin, M.D.*

Mar. 26—To be announced.

Apr. 24—Speaker, Harvey E. Thorpe, M.D., Pittsburgh, Pa. Topic, Management of Intra-ocular Foreign Bodies.

Wisconsin Society of Internal Medicine

Dr. Leslie G. Kindschi, Monroe, was installed as president of the Wisconsin Society of Internal Medicine during the group's annual meeting September 16, held at Land O' Lakes. Doctor Kindschi succeeded *Dr. Robert L. Gilbert,* La Crosse. *Dr. Warren K. Simmons,* Rhinelander, was elected president-elect, and *Dr. William L. Coffey, Jr.,* Milwaukee, was elected secretary-treasurer.

Seventy-five internists attended the three-day program which featured a scientific presentation on the "Pathogenesis and Immunology of Rheumatoid Arthritis" and a full day's postgraduate course on hematology.

Doctor Kindschi is a charter member of the Wisconsin Society which was organized in 1955. The Society currently has 184 members. He has served as chairman of the Society's Public Relations Committee, as a delegate to the American Society of Internal Medicine and on the Society's Postgraduate Education Committee. He was elected to the Society's governing council in 1957 and served as secretary-treasurer in 1959.

Physicians whose names appear in italic are members of the State Medical Society.

Wisconsin Radiological Society

The 12th annual meeting of the Wisconsin Radiological Society was held September 15–17 at Brown's Lake Resort, Brown's Lake. Guest speakers were Drs. Marion F. Magalotti, director of the Radiation Therapy Center, Cook County Hospital, Chicago, Illinois, and Dr. Eugene C. Klatte, assistant professor of radiology, University of Indiana Medical School, Indianapolis, Indiana. Doctor Magalotti discussed the newer concepts of Iodine—131 therapy of thyroid disease and supervoltage therapy with Tele-cobalt and Tele-cesium. Doctor Klatte discussed aortic valvular disease in children and adults and intestinal obstruction in the newborn. Other speakers were *Drs. John Amberg, Abraham Melamed, E. P. Onderak,* and *Frank Zboralske* of Milwaukee, and *Dr. I. Nik Nevin* of Rhinelander.

Dr. John H. Juhl of Madison was elected president to succeed *Dr. Farrel F. Golden* of Madison. *Dr. Hobart Wright* of Milwaukee was named president-elect and *Dr. Howard G. Bayley, Jr.* of Beaver Dam was re-elected secretary-treasurer. Doctor Golden was also elected to the Board of Directors along with *Dr. Donald Ryan,* of Neenah. *Dr. Irving Cowan* of Milwaukee was re-elected as Councilor to The American College of Radiology.

New active members elected into the Society were *Drs. Constance Erwin, Thomas C. Lipscomb,* and *Richard Zellmer* of Milwaukee, *Dr. Robert Songe* of Wausau, *Dr. Nikolaus Theisen* of Escanaba, Michigan, and Drs. Thomas Bolitho, James Carter, and

SPECIALTY SOCIETY PROCEEDINGS

continued

Douglas Erickson of Marquette, Michigan, and *Dr. Charles Benkendorf* of Green Bay. E. Dale Trout, D.Sc. of Milwaukee and John R. Cameron, Ph.D., of Madison were elected to honorary membership as radiation physicists who have made outstanding contributions to radiology.

Wisconsin Academy of General Practice

Dr. Joseph S. Devitt, Milwaukee, the medical chief of staff at St. Mary's Hospital and a former head of The Medical Society of Milwaukee County, was named president-elect of the Wisconsin Academy of General Practice during the annual meeting held September 17–19 in Milwaukee. Doctor Devitt will succeed *Dr. Albert H. Stahmer,* Wausau, physician and surgeon, who assumed the presidency of the organization at this meeting.

Other officers are: *Drs. John A. Kelble,* Milwaukee, re-elected secretary-treasurer; *Norbert G. Bauch,* Milwaukee, speaker of the House of Delegates; and *Howard Klopf,* Milwaukee; *John Jamieson,* Racine; and *Emmett R. Killeen,* Green Bay, directors.

Dr. Robert F. Purtell, Milwaukee, was re-elected a delegate to the American Academy, and *Dr. David N. Goldstein,* Kenosha, was named an alternate.

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NEWS OF WISCONSIN PHYSICIANS

Doctor Banyai Lectures in East

Dr. Andrew L. Banyai, Chicago, Illinois, clinical professor of medicine emeritus of Marquette University School of Medicine, Milwaukee, delivered a lecture at the annual Gordon Research Conferences, Section on Medicinal Chemistry, held at Colby Junior College, New London, New Hampshire, July 31–August 4. The subject of his presentation was "Shortcomings of Medicinal Therapy in Lung Diseases and Their Possible Correction."

Doctor Boyle Heads Physical Medicine Academy

Dr. Robert W. Boyle, director of physical medicine and rehabilitation at the Milwaukee County General Hospital, was installed as president of the American Academy of Physical Medicine and Rehabilitation at the academy's annual meeting in Cleveland, Ohio, early in September. Doctor Boyle succeeded *Dr. Ray Piaskoski*, professor and chairman of the department of physical medicine and rehabilitation at Marquette University School of Medicine. Doctor Boyle also is a professor in that department at Marquette.

Milwaukeean Named GP of the Year

Dr. John W. Maxwell, Milwaukee, was named "general practitioner of the year" by the National Medical Association at its 66th annual convention held in New York City in mid-August. Doctor Maxwell was named chief of staff at St. Anthony's Hospital in 1954. He began practice in Nashville, Tenn., in 1929, and moved to Milwaukee in 1946.

Dr. Robin Allin To Address Parish

Dr. Robin Allin, Madison, will address St. Patrick's Parish November 28 at 8:00 p.m. on the subject of health care of the aged.

Three New Physicians in Madison

Dr. Roger Kushner is a new pediatric resident at University Hospitals. He moved to Madison from Indianapolis, Ind., where he was associated with the Medical Center.

A new resident in psychiatry at University Hospitals is Dr. Arnold Marx who was formerly associated with Cedars of Lebanon Hospital in Los Angeles, Calif.

Dr. Ean Crennell of Rochester, Minn., has joined the Madison Physician Anesthetists. He did postgraduate work at the Mayo Clinic before moving to Madison.

Dr. D. A. Gutheil Moves to De Pere

Dr. D. A. Gutheil, medical director for Maple Crest Sanatorium at Whitelaw, moved his residence to De Pere on Sept. 1. The move was made because of the increased work at Hickory Grove Sanatorium where he also serves as medical director. He will continue serving the Maple Crest Sanatorium.

Doctor Kemper is an Ornithologist, Too

Dr. Charles A. Kemper, who practices medicine in Chippewa Falls, also finds time to enjoy an ornithology hobby. He has banded more than 13,000 birds in the last five years. He caught most of these on an 80-acre tract where he planted thousands of trees and shrubs to attract the birds. Considered an authority on the subject in his region, Doctor Kemper writes many articles, shows films and gives speeches on wildlife. He has begun writing a book on Chippewa County wildlife which will be illustrated with his own sketches.

Brookfield News Photo

R. S. PAVLIC, M.D.

Eau Claire Leader Photo

C. A. KEMPER, M.D.

Brookfield Physician Likes Hobby in Magic

Dr. Robert S. Pavlic, Brookfield obstetrician and gynecologist, has gained national recognition as a leading mentalist. Probably his most widely known fetes are the predicting of newspaper headlines in advance and his five-mile trip driving a car through the main section of San Antonio, Texas, while blindfolded. The doctor has studied magic since sixth grade and says that his predictions are based on sound psychological and scientific principles. In October, Doctor Pavlic will appear before the Underwood Woman's Club in Wauwatosa, the Deaconess hospital auxiliary in January and at the Pewaukee Woman's Club in February.

New Physician at Hales Corners

Dr. Ildefonso L. Asinas has begun practicing in Hales Corners as an associate of *Dr. Nicholas Damiano*. He is a native of Manila, Philippines. He received his medical degree in 1955 from the Univer-

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Physicians whose names appear in italic are members of the State Medical Society.

sity of Santa Tomas, Manila, the Catholic University of the Philippines.

Doctor Asinas came to the United States in July of 1956 for postgraduate medical training under the Exchange Visitors' program. He interned at St. Francis Hospital, La Crosse, until July 1957 when he became a resident in general practice at Suburban Hospital, Bethesda, Md. In 1958, Doctor Asinas accepted a residency, in general practice at St. Luke's Hospital, Milwaukee, and the following year served in the fields of obstetrics and gynecology at that hospital. Prior to setting up practice in Hales Corners, Doctor Asinas was a resident in obstetrics and gynecology at St. Francis Hospital from 1960 to 1961.

Chetek Physicians Welcomed

Eau Claire Leader Photo

A welcome to Chetek is offered by *Dr. R. W. Adams*, left, to Dr. Joseph E. Powell, center, and Dr. Max C. Roller, right. The two new physicians recently located in the community with a good assist from the State Medical Society's Placement Service.

Dr. E. H. Pawsat Speaker at Rotary Meet

Dr. E. H. Pawsat, Fond du Lac, told members of the Fond du Lac Rotary Club that American youth are "overweight, poorly-postured and flabby" and called for more strenuous physical education programs to overcome the serious shortages in conditioning. Speaking at a noon luncheon on August 21 Doctor Pawsat pointed out that youth today has become "pampered and poorly disciplined" in its outlook, a victim of the automobile and television set. He praised several organizations throughout the country which have initiated youth-fitness programs. Doctor Pawsat is a former member of the citizen's advisory committee on fitness of American youth.

Associates with Janesville Medical Center

Dr. Hugh W. Simonsen became associated with the Janesville Medical Center in August. He is a 1957 graduate of the University of Wisconsin Medical School. He served his residency in internal medicine at Milwaukee County Hospital from 1958 to 1961.

New Physician at Juneau

Dr. Frederic Haessly, a native of Milwaukee, has begun practice at Juneau. He is a 1957 graduate of the Marquette University School of Medicine. After interning at Fitzsimmons Army Hospital in Denver, Doctor Haessly entered military service. He was discharged in July.

Doctor Close Named Chief of Surgery

Dr. A. Stephen Close was named chief of surgery at Wood VA Hospital early in August. He replaces *Dr. Miles B. Smith*, who resigned to enter private practice. A 1949 graduate of the Albany, New York, medical college, Doctor Close has been assistant chief of surgery since 1959 and also director of surgical research at Wood. He is an assistant professor of surgery at Marquette University School of Medicine.

Dr. Alice Watts Has New Associate

On August 15, Dr. Helen M. Worsencroft joined *Dr. Alice D. Watts* in the practice of obstetrics and gynecology in Milwaukee. Doctor Worsencroft is a 1956 graduate of the University of Wisconsin Medical School and served her internship at the George Washington University Hospital in Washington, D. C. Following her internship she served four years as a resident in obstetrics and gynecology at the Washington Hospital Center in Washington, D. C.

Milwaukee Physicians Named to Heart Association

Dr. Raymond L. Rice, Milwaukee, was named president-elect of the Wisconsin Heart Association at its 13th annual meeting in June. Doctor Rice has been a Board member of the Association since 1952. New members elected to the Board of Directors for three-year terms include: *Drs. Howard L. Correll, Francis F. Rosenbaum*, and *Lamont R. Schweiger*, all of Milwaukee.

Doctor Rice and *Dr. Robert A. Frisch*, Milwaukee, were elected voting delegates to the American Heart Association for 1961–1962. The following physicians were also named chairmen of various committees of the Wisconsin Heart Association: Doctors Frisch, community service and education; Correll, research; *Ross C. Kory*, physician education; and *John H. Huston*, Dr. Malcolm F. Rogers Lectures committee.

Doctor Gaenslen Recognized in POST

An article entitled "Doctors in the Desert," which appeared in the July 22 issue of the SATURDAY EVENING POST, gave credit to *Dr. Frederick Gaenslen*, Milwaukee, for bringing 3,500 case records of the Orthopedic Letters Club Overseas Project (OLCOP) in Jordan up to date. Under this program, each member of the Orthopedic Letters Club spends one month in Jordan treating the crippled and underprivileged and sharing his knowledge with medical personnel. Doctor Gaenslen also participated in the treatment program in Jordan in November and December, 1960.

Doctor Devitt Addresses Dental Society

Dr. Joseph S. Devitt, Milwaukee, addressed the Board of Directors of the Greater Milwaukee Dental Society on July 19 at the YMCA. The subject presented was "Health Care for the Aged."

Doctor Hildebrand Speaks on Aged Care

Dr. W. B. Hildebrand, Menasha, has been speaking to a number of organizations in his area explaining the need for support of the Kerr-Mills Law, and at the same time expressing the medical profession's views regarding the King-Anderson bill. In August, Doctor Hildebrand addressed the Oshkosh and Green Bay Rotary Clubs on separate occasions, and later this fall he will be addressing another group in the Upper Peninsula.

Doctor Davis Addresses Medical Technologists

Dr. D. W. Davis, Kenosha pediatrician, addressed the Racine–Kenosha Chapter of the Wisconsin Association of Medical Technologists at the Kenosha Hospital on September 6.

Doctor Neupert Featured in Newspaper

Dr. Carl N. Neupert, State Health Officer, Madison, was featured in the WISCONSIN STATE JOURNAL'S "Know Your Madisonian" column on August 27. Appearing with the article was a photo-sketch by Edward Schumann.

Doctor Church Addresses Lions Club

Dr. Ruth Church, new medical director of Waukesha County, addressed members of the Waukesha Lions Club on August 23. She explained her views concerning the development of a county health department.

Five-County Meeting of Physicians

Physicians from five counties met August 24 at the Port Washington Country Club for a scientific meeting dealing with developments in the field of orthopedics. Speakers included Dr. James K. Stack, Chicago, *Drs. David J. Ansfield* and *Frederick Gaenslen* of the Marquette University School of Medicine. *Dr. Robert J. Samp* of the University of Wisconsin Medical School spoke at the evening dinner meeting. His talk dealt with modern quackery. The meeting was sponsored by the Fifth Councilor District of the State Medical Society and the Wisconsin Academy of General Practice. Counties included Sheboygan, Calumet, Washington, Ozaukee and Manitowoc.

Doctor Crocker Opens Practice in Madison

Dr. Laurence G. Crocker has begun medical practice with *Dr. Anthony J. Richtsmeier* in the Tenney Building in Madison. Doctor Crocker served his internship from 1955 to 1956 and his residency in internal medicine from 1958 until 1961 at University Hospitals, Madison. He is a member of the Madison VA hospital medical staff and is clinical instructor at the University of Wisconsin Medical School.

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MEDICAL MEETINGS—POSTGRADUATE COURSES

Mount Sinai Hospital Course

The Mount Sinai Hospital staff, Milwaukee, will present a course on "1961 Clinical Advances and Review" November 1, 2, 8 and 9. The course consists of four morning sessions from 9 a.m. to 1 p.m. Registration fee is $25. Members of the American Academy of General Practice in attendance will receive 12 hours of Category I credit.

UW Postgraduate Courses

A course designed to review the care of the increasing number of patients who survive traumatic injury to the spinal cord will be presented Nov. 16–18 at the University of Wisconsin Medical Center, Madison. Dr. Arthur A. Siebens, director of the Respiratory and Rehabilitation Center, is program chairman. Current concepts of the neurophysiological basis of voluntary motion and muscle tone will be presented, together with principles of acute and chronic care.

"Problems and Perspectives in Medicine" will be presented Jan. 18–20, 1962, under the direction of Dr. Ovid O. Meyer, chairman of the Department of Medicine. The program is planned to include such subject matter as the rapidly developing fields of auto-immune diseases, anomalies of chromosome distribution in the causation of disease and other clinically applicable aspects of medical genetics. The diagnosis of kidney disease as modified by biopsy, the management of acute renal insufficiency and the use of drugs in cardiac failure will be discussed.

Further information may be obtained by writing to: Coordinator, Postgraduate Program in Medical Education, The Wisconsin Center, 702 Langdon Street, Madison 6, Wis.

American College of Physicians

"The Internist's Role in Preoperative and Postoperative Problems" will be the subject of a postgraduate course sponsored by the American College of Physicians, Nov. 6–10. The course will be conducted at the Mayo Clinic in Rochester, Minn.

Chicago Diabetes Association

The Chicago Diabetes Association will conduct its Fifth Annual Symposium on Diabetes at the Offield Auditorium, Passavant Memorial Hospital, 303 East Superior Street, Friday, November 10, beginning at 9 o'clock.

Registration is free for members of the Chicago Diabetes Association or the American Diabetes Association and for medical students and resident house staff members. The fee for non-members is $25.00. Members of the Academy of General Practice may claim hour for hour credit in Category II. Inquiries may be addressed to: The Chicago Diabetes Association, 620 North Michigan Avenue, Chicago 11, Illinois.

American Speech and Hearing Association

Five of the nation's leading specialists in cerebral palsy will discuss neuromuscular, brain and therapy problems relating to speech handicaps of the cerebral palsy patient in an unique symposium at the convention of the American Speech and Hearing Association, November 7, in Chicago, at Hotel Sherman.

WISCONSIN CALENDAR COMING EVENTS

1961

Nov. 1, 2, 8, 9: Mount Sinai Hospital postgraduate course on "1961 Clinical Advances and Review," Milwaukee.

Nov. 2: UW half-day course for GPs on "Frequent Surgical Problems Occurring in General Practice," Madison.

Nov. 13–17: Annual meeting, American Public Health Association, Detroit, Mich.

Nov. 16–18: Milwaukee Divisional Meeting of the American Psychiatric Association, Milwaukee.

Nov. 16–18: UW postgraduate course, Rehabilitation of Patients with Injuries of the Spinal Cord, Dr. A. Siebens, chrm., Wisconsin Center Building, Madison.

Nov. 26–30: AMA Clinical Meeting, Denver, Colorado.

1962

Apr. 5–7: UW postgraduate course, Genetics in Pediatrics, Drs. J. Crow and N. Smith, co-chrm., Wisconsin Center Building, Madison.

Apr. 26–28: UW postgraduate course, Psychosomatic Medicine, Dr. David Graham, chrm., Wisconsin Center Building, Madison.

May 8–10: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 10–11: UW postgraduate course, Orthopedic Surgery, Dr. H. Wirka, chrm., Wisconsin Center Building, Madison.

May 17–19: UW postgraduate course, Anatomy, Physiology and Pathology of the Holocrine, Apocrine and Eccrine Glands, Dr. S. Johnson, chrm., Wisconsin Center Building, Madison.

June 24–28: AMA Annual Meeting, Chicago, Illinois.

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California.

Facts about

WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON MEDICAL CARE PLANS

THE SPECIAL SERVICE POLICY

The impetus for the idea of the WPS no fee schedule medical policy was the continuing demand by industry and unions for full payment contracts for workers at greatly varying wage levels.

To develop fee schedules for each of the various income levels would create an intolerable and administratively unworkable situation. In addition, physicians were generally not happy with the rigidity of fee schedules.

Once established, a fee schedule is difficult to change. The thought was often expressed that if fee schedules were not needed, the public would benefit. Without fee schedules, needed fee and rate increases, due to rising costs, could be put into effect as they occurred.

To meet this growing problem, the idea of developing a medical care policy that would pay the usual, customary and reasonable fees charged by physicians was born. WPS calls this the "Special Service" policy.

The first policy was issued November 1, 1955. There are over 50,000 subscriber contracts in effect.

Since the State Medical Society is the real authority for the no fee schedule plan, it is responsible also for making it work.

Since the one salient feature of the plan is the payment directly to the servicing physician of a fee which is "usual, customary and reasonable" for the services performed, it is incumbent on the Society to provide means of doing just that.

Further, the policy indicates that WPS will "stand in the place of the patient" in disputes concerning charges made by physicians for care given the subscriber and/or insured members of his family, subject to certain contractual exceptions.

To carry out these responsibilities the State Medical Society has asked each county medical society to establish an Advisory Committee. The function of this Committee is to advise WPS on what it regards the "customary, usual and reasonable" fees charged by physicians in their medical communities in those cases referred to them for such determination. These Committees now serve a very important function in the success of a highly popular program of prepaid health care.

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THE DOCTORS' PLAN OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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COUNTY SOCIETY PROCEEDINGS

BARRON-WASHBURN-SAWYER-BURNETT

Nineteen members of the Barron-Washburn-Sawyer-Burnett County Medical Society met October 10 at the Elks Club in Rice Lake. Guest speaker was Lt. Gov. Warren Knowles who spoke on politics and medicine. The Society accepted two new members: Drs. Mac C. Roller and Joseph E. Powell, who recently began practicing at Chetek.

BROWN

Members of the Brown County Medical Society met October 12 at the Elks Club in Green Bay. Program for the meeting consisted of the showing of a ten-minute film strip arranged by Mr. Mortell on the subject of professional liability insurance. A question and answer period followed.

There was also discussion of meetings on civil defense and disaster medical care.

CHIPPEWA

The meeting of the Chippewa County Medical Society was held October 12. The group inspected the new Bloomer Community Memorial Hospital before conducting the meeting. At the close of the meeting surgical films were shown.

DANE

Officers for the 1961–1962 year of the Dane County Medical Society are as follows:

President: *Dr. A. P. Schoenenberger*, Madison
President-elect: *Dr. Robin N. Allin*, Madison
Vice-president: *Dr. W. A. Tanner*, Madison
Secretary-Treasurer: *Dr. D. A. Peterson*, Madison

Board of Trustees includes the officers and the following: *Dr. C. K. Kincaid, Dr. P. R. Kundert, Dr. H. W. Wirka, Dr. W. E. Meisekothen, Dr. J. J. Mueller, Dr. F. E. Mohs*, and *Dr. C. W. Stoops*, Madison; and *Dr. V. W. Nordholm*, Stoughton; *Dr. W. T. Russell*, Sun Prairie; and *Dr. L. S. Kellogg*, Oregon.

Election of officers was held October 10 at the State Medical Society building.

DODGE

At the September meeting of the Beaver Dam Medical Forum, *Dr. R. E. Urbanek* presented a classification of medications used in the treatment of psychiatric disorders and also commented on the effectiveness of the various medications. Contraindications and side reactions were discussed and the marked variation and individual dosage was also considered.

Physicians whose names appear in italic are members of the State Medical Society.

GRANT

Members of the Grant County Medical Society heard *Dr. R. E. O'Connor*, Madison, speak on "Handling of Children's Behavior in Medical Practice" at the September 28 meeting in Lancaster. Doctor O'Connor, assistant clinical professor of psychiatry at the University of Wisconsin Medical Center, appeared under auspices of the Charitable, Educational and Scientific Foundation and under grant from the State Board of Health.

The group discussed safety football helmets after which it was recommended that the secretary write to the Wisconsin Athletic Insurance Association requesting a thorough investigation on what would be the most protective and yet the least harmful type of helmet. Interest in the subject was aroused when a 15 year old boy suffered a tragic injury in a Boscobel-Fennimore game.

JEFFERSON

Dr. G. S. Kilkenny, Milwaukee, was guest speaker at the September 21 meeting of the Jefferson County Medical Society held at the Meadow Springs Country Club in Jefferson. Doctor Kilkenny, associate clinical professor of obstetrics and gynecology at Marquette University School of Medicine, talked on "Endocrine Basis of Abnormal Uterine Bleeding." His appearance was sponsored by the Charitable, Educational and Scientific Foundation under a grant from the State Board of Health.

LINCOLN

Dr. Robin Allin, a Madison internist, spoke to the Lincoln County Medical Society September 28 at the Badger Hotel in Merrill. His talk was on cardiac emergencies. His appearance was sponsored by the CES Foundation under a grant from the Wisconsin Heart Association.

MARATHON

Stephen Gavin, representing the State Medical Society, spoke September 26 to members of the Marathon County Medical Society and its Auxiliary at the Wausau Club in Wausau. Among topics discussed were the state sales tax, the Service Corporation Law, the Kerr-Mills Act and other legislative matters.

A motion by *Dr. A. W. Hoessel*, Wausau, was passed commending *Dr. A. H. Stahmer*, Wausau, on his election as president of the Wisconsin Academy of General Practice.

ONEIDA-VILAS

Members of the Oneida-Vilas County Medical Society heard *Dr. R. F. Schilling*, associate professor of medicine at the University of Wisconsin Medical

School, Madison, talk on leukemia at its October 18 meeting, held at St. Mary's Hospital in Rhinelander. His appearance was sponsored by the CES Foundation under a grant from the American Cancer Society, Wisconsin Division.

OUTAGAMIE

"Current Practice in the Management of Thyroidal Disease" was the topic discussed by Dr. R. Marden Black at the September 21 meeting of the Outagamie County Medical Society held at the Hotel Conway in Appleton. Doctor Black is professor of surgery at the Mayo Clinic, Rochester, Minn.

Dr. Harold G. Cooper and Dr. L. T. Plouff of Appleton were accepted as new members. Forty-seven members were present.

The October 19 meeting of the Society was held at the Riverview Sanatorium in Kaukauna. The following officers were elected: president—*Dr. J. N. Bonner*, vice president—*Dr. F. M. Hauch*, and secretary—*Dr. J. G. Anderson*, all of Appleton.

Society delegates gave their yearly reports, and Dr. David Shapiro of Appleton was accepted as a new member.

PIERCE-ST. CROIX

Members of the Pierce-St. Croix County Medical Society met at Hotel Walvern in River Falls October 17 and heard *Dr. C. Weir Horswill* discuss "Hemorrhage as a Leading Cause of Maternal Death." He is a Madison gynecologist and obstetrician. *Dr. Roland M. Hammer* was host for the meeting.

The September 19 meeting was held at Hotel Dibbo in Hudson with *Dr. Gerald E. Bourget* as host.

RICHLAND

Ten members were present for the October 5 meeting of the Richland County Medical Society. They met at the Richland Hospital library in Richland Center. *Dr. William H. Ylitalo* and *Dr. Robin N. Allin* of Madison talked on rheumatic heart disease. The talk followed the Rheumatic Fever Clinic.

SAUK

Members of the Sauk County Medical Society heard *Dr. Fred J. Ansfield*, Madison, talk on hormonal therapy of disseminated cancer and the family physician in this. The meeting was held September 12 at the Warren Hotel in Baraboo.

Doctor Ansfield is associate professor of cancer research at the University of Wisconsin Medical School. His appearance was sponsored by the CES Foundation under a grant by the American Cancer Society, Wisconsin Division.

TREMPEALEAU-JACKSON-BUFFALO

Dr. Ubaldo Alvarez of La Crosse addressed 12 members of the Trempealeau-Jackson-Buffalo County Medical Society July 25 at Club Midway in Independence. His topic was "Choriocarcinoma and Hydatid Mole."

On September 26, *Dr. Paul W. Phillips* of La Crosse spoke on orthopedic fractures at the Society meeting held at Club Midway in Independence.

Dr. Thomas P. Chisholm of Arcadia was accepted as a new member.

WINNEBAGO

The Winnebago County Medical Society met October 12 at the Neenah-Menasha Elks Club. Principal speaker was Dr. Robert K. Ousmann of Roswell Park, Buffalo, N. Y. With the help of Baxter Laboratories and the Theda Clark Hospital team, Doctor Ousmann demonstrated and explained the artificial kidney. Physicians from Waupaca and Outagamie counties were invited guests.

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NEWS OF WISCONSIN PHYSICIANS

Barron Physician Returns from Europe

Dr. M. S. Saydjari returned to Barron July 30 after a month's tour of Europe. During the trip Doctor Saydjari attended a surgical conference in New York City, a meeting of the International Surgical Congress in Vienna, Austria, and vascular surgery sessions in Stockholm, Sweden. He also visited Spain, England, Germany, Switzerland, Italy, Turkey, Lebanon where he visited relatives, and Denmark.

Waukesha Daily Freeman Photo

Dr. William B. Campbell, Waukesha, sorts his hand for another game of bridge, one of his pleasant pasttimes.

Doctor Campbell Featured in Newspaper

Dr. William B. Campbell, 83-year-old Waukesha physician, was featured in a September issue of the WAUKESHA DAILY FREEMAN. Doctor Campbell recalled his early days of medical practice, noting that he purchased his first automobile in 1908, but considered it too risky trusting the roads in those days. He has delivered approximately 3,500 babies, most of them in the farming area around Menomonee Falls. He began his practice in Waukesha 42 years ago in 1919. Doctor Campbell is a Fifty-Year Club member of the State Medical Society of Wisconsin and a lifetime member of the State Society and the American Medical Association. One of the doctor's hobbies is collecting art. He is a champion at bridge, too, having won a trophy this year for the most successful defense at the Minocqua Lakeland tournament.

Physicians whose names appear in italic are members of the State Medical Society.

Doctor Garner Presents Exhibit

Dr. Lawrence L. Garner, director of the Glaucoma Referral Center at the Marquette University School of Medicine, Milwaukee, in collaboration with *Dr. E. Franklin Carl* and Dr. James R. Ferwerda, presented an exhibit at the sixty-sixth annual convention of the American Academy of Ophthalmology and Otolaryngology held October 8–13 at the Palmer House in Chicago, Ill. Title of the scientific exhibit was "Acetazolamide (Sustained Release) in Glaucoma; Comparison with Conventional Carbonic Anhydrase Inhibitors." The three physicians represent Marquette University School of Medicine, County General Hospital and the Veterans Administration, Regional Office, Milwaukee.

Joins Janesville Medical Center Staff

Dr. Richard P. Whereatt has joined the staff of the Janesville Medical Center for the practice of surgery. Doctor Whereatt, a native of Superior, graduated from the Marquette University School of Medicine in 1954, then interned at St. Joseph's Hospital in Milwaukee for one year. After spending two years in the U. S. Army medical corps, he served a residency in surgery at the Illinois Central Hospital, Chicago, from 1957 to 1961.

Doctor Alvarez to Philippines

Dr. Ricardo L. Alvarez of Galesville visited the Philippines while on a vacation in October. His practice was handled by his son, Dr. Richard Alvarez, Jr.

Qualify for American College of Surgeons

Fourteen Wisconsin physicians were among the 1,103 initiates who became Fellows of the American College of Surgeons at the annual clinical congress held October 2–6 in Chicago. They are:

Richard J. Botham, M.D. ..... Madison
Wayne J. Boulanger, M.D. ..... Milwaukee
Gordon Davenport, M.D. ..... Madison
Bruce L. Gargas, M.D. ..... Wausau
Milton F. Cutglass, M.D. ..... Milwaukee
Russell F. Lewis, M.D. ..... Marshfield
Thomas G. Malloy, M.D. ..... Milwaukee
Timothy H. McDonnell, M.D., ... Waukesha
Robert S. Monk, M.D. ..... Waukesha
Walter H. Pinkus, M.D. ..... Racine
Bahij S. Salibi, M.D. ..... Marshfield
Wesley R. Shaw, M.D. ..... Wausau
John H. Turgeson, M.D. ..... Madison
Gail H. Williams, M.D. ..... Marshfield

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Vitamin C	200 mg.
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Dr. Frank T. Weber, Arcadia, a general practitioner with a special interest in eye, ear, nose and throat, died August 13, 1961, at the age of 70.

Born in Germany in 1891, Doctor Weber was a 1919 graduate of the Marquette University School of Medicine, Milwaukee. He began his practice in Arcadia that same year and served that community until shortly before his death. He took postgraduate training in eye, ear, nose and throat at the Chicago EENT College and the Illinois Medical College.

He served as president and secretary of the Trempealeau, Buffalo, Jackson County Medical Society and was a member of the State Medical Society of Wisconsin and the American Medical Association.

It was mainly through the efforts of Doctor Weber that Arcadia obtained a hospital in 1936.

Surviving are his widow; one daughter, Mrs. Paul Galewski of Detroit, Michigan; and four sons, Francis, Sheboygan Falls; James, Milwaukee; William, Chippewa Falls; and John, Moline, Illinois.

Dr. Edward C. Pfeifer, a general practitioner for over 48 years and practicing in Racine for 42 years, died August 19, 1961, at the age of 73.

Born in Kewaskum, Wisconsin, Doctor Pfeifer was a 1913 graduate of Northwestern University Medical School. Following internship at the Alexian Brothers Hospital in Chicago, he practiced at Loyal, Wisconsin, until entering military service in 1917. Upon his return to Racine, he was associated with his brother, the late Dr. A. S. Pfeiffer, and later on with another brother, Dr. Oliver Pfeiffer, presently of Woodruff, Wisconsin.

His medical affiliations included the Racine County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He was a staff member of St. Mary's and St. Luke's hospitals, Racine. His father, who preceded him in death, Dr. Charles Pfeifer, had practiced in Sheboygan Falls, Wisconsin.

Surviving are his widow, Roxie; one son, Robert, of Durham, California; and a daughter, Dr. Grace Pfeifer, of Park Ridge, Illinois.

Dr. Frank B. Marek, a general practitioner in Racine for 43 years, died August 24, 1961, at the age of 71.

A native of Bohemia, Doctor Marek received his medical degree from Rush Medical College, Chicago, Illinois, in 1915. He took his internship at Los Angeles County Hospital, Los Angeles, California, and served a residency at St. Mary's Hospital, Madison, before entering private practice in Racine. He was a veteran of the Mexican Campaign in 1916, serving in a U. S. Army field hospital.

A past president of the Racine County Medical Society, he was also a member of the State Medical Society of Wisconsin and the American Medical Association.

Surviving are his widow, Cora, and three children.

Dr. Arthur V. de Neveu, Wyocena, a former deputy state health commissioner, died August 27, 1961, at the age of 83.

A native of Green Bay, he was a 1903 graduate of the University of Illinois Medical School. After internship and residency at Green Bay General Hospital from 1903 to 1904, he practiced in Tish Mills, Wisconsin, until 1914, when he moved to Wyocena. Appointed deputy state health commissioner in 1923, he moved to Rhinelander. In 1927 he was appointed director at Johnson Emergency Hospital in Milwaukee, where he stayed until 1944 when he returned to Wyocena to again become deputy state health commissioner and resident physician at Columbia County Hospital and Home.

An amateur artist of renown, he won prizes at art shows in Atlantic City, New Jersey, and San Francisco, California, as well as many Wisconsin events.

A member of the Columbia County Medical Society, he served as delegate to the State Medical Society at one time. He was a life member of the State Medical Society of Wisconsin and a member of its Fifty Year Club, and a member of the American Medical Association.

Surviving are his widow, Nora; a son, Elwood of Darien; and two daughters, Mrs. Robert Ray, Milwaukee, and Mrs. Arthur Konnelly, Mishicot.

Dr. M. H. Draper, a former practitioner in Deerfield, Wisconsin, died August 11, 1961, in Bay Pines Veterans Hospital, Florida, at the age of 77.

A native of Dodgeville, Doctor Draper was a graduate of Rush Medical College, Chicago. He had been a practicing physician for 51 years, specializing in chest diseases. He practiced in Deerfield about 40 years ago. Doctor Draper was a former medical director of the Florida State Tuberculosis Hospital, Tampa, and had been medical consultant for the Veterans Administration Hospital at Bay Pines for the past 14 years. Prior to that time he practiced in Fort Wayne, Indiana.

He was formerly a member of the Indiana State Medical Society, and had been honored by that society for 50 years of medical practice. He was also a member of the American Medical Association.

Surviving are his widow, Esther; two sons, Robert F. of Eau Claire and William A. of Pompano Beach, Florida.

Dr. Leslie E. Coffin, Tucson, Arizona, who formerly practiced in Kenosha, died August 14, 1961, at the age of 78.

A native of Maine, he was a graduate of Harvard Medical School, Boston, Massachusetts in 1904. After internship at Foxboro, Massachusetts, State Hospital, he practiced in Michigan from 1908 until 1945, when he established his practice in Kenosha. He moved to Tucson in 1950.

Doctor Coffin was formerly a member of the Kenosha County Medical Society, was a member of the State Medical Society of Wisconsin's Fifty Year Club, the American Medical Association, and the American College of Surgeons.

Surviving are his widow, two daughters and one son.

Dr. William B. Cornwall, Amery, a general practitioner with a special interest in surgery, died August 27, 1961, at the age of 74.

A native of Barron County, Wisconsin, Doctor Cornwall was a 1911 graduate of Marquette University School of Medicine. He practiced for a time in Turtle Lake, moving to Amery in 1919 following service in World War II. He practiced in Amery for 43 years and founded the Cornwall Clinic. Doctor Cornwall retired in 1958 for health reasons.

A past president of the Polk County Medical Society and member of the State Medical Society of Wisconsin, he became a member of the State Society's Fifty Year Club in 1961. He was also a member of the American Medical Association.

Surviving are his widow and one daughter, Mrs. K. G. Framsted, of California.

Dr. Edward O. Gertenbach, Milwaukee, a specialist in surgery, died September 1, 1961, at the age of 60.

A native of Racine, Doctor Gertenbach was a 1927 graduate of Northwestern University Medical School. After serving his internship at Milwaukee Hospital, he trained in surgery under Drs. Harry Sifton and Curtis Evans for a number of years.

A member of the Milwaukee County Medical Society, he served as the organization's secretary at one time. He was also a member of the State Medical Society of Wisconsin and the American Medical Association. He was a Fellow of the American College of Surgeons and the International College of Surgeons, also a member of the American Society of Abdominal Surgeons.

He is survived by his widow, Jessamine.

Dr. Henry N. Winn, Madison, a specialist in radiology, died September 8, 1961, at the age of 68.

A native of Poynette, Doctor Winn was a graduate of Rush Medical College, Chicago, in 1917. He was a veteran of World War I, serving as a medical officer in the navy.

Doctor Winn established his practice in Madison in 1926 and remained active until May of this year. From 1927 through 1948 he was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow; three daughters, Mrs. R. C. Anderson, Madison, Mrs. Joseph Lorenz, San Diego, California, and Mrs. Thomas Lucas, New Holstein; and a son, Robert, of Waukesha.

Dr. Hans A. Hoyer, Milwaukee general practitioner, died September 14, 1961, at the age of 65.

A native of Milwaukee, Doctor Hoyer was a 1921 graduate of the Detroit College of Medicine and Surgery in Detroit, Michigan. Following internship at Evangelical Deaconess Hospital in that city, he established his practice in Milwaukee. In addition to his private practice, he served as a surgeon for the Milwaukee Police Department, and as physician for Cutler-Hammer, Inc. in Milwaukee.

His medical affiliations included The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Elsie, one son and one daughter.

Dr. Jacob S. Tenney, physician in Alma since 1895, died September 22, 1961, at the age of 91.

A native of Minnesota, Doctor Tenney was a graduate of the University of Minnesota Medical School in 1895. He came to Alma after graduation, and except for a year's internship at City and County Hospital, St. Paul, Minnesota, shortly thereafter, practiced in that community full time until 1936 when he was forced to limit his practice for health reasons. In 1948, he was honored by Alma residents for over 50 years of medical service to the community.

Doctor Tenney served as mayor of Alma for two terms, and was director of the Board of Education at one time. His activities to better serve the rural people of the area resulted in the first telephone company established in that area, and he owned the first auto in Alma, to be more readily available to serve the medical needs of people outside the community.

Dr. Rudolph J. Depner, Milwaukee, a specialist in administrative psychiatry, died September 26, 1961, at the age of 56.

A native of Rhode Island, Doctor Depner was a 1932 graduate of Duke University Medical School, Durham, North Carolina. He interned at Worchester, Mass., State Hospital and Kansas City, Mo., General Hospital, and received postgraduate training at the New York Psychiatric Institute, New York Neurological Institute, Columbia Medical School, Montifiore Hospital, Metropolitan State Hospital, Boston Psychiatric Hospital, and Worchester, Mass., State Hospital.

Doctor Depner previously practiced in Rhode Island, New York, New Hampshire, Massachusetts, Washington and Maryland before coming to Wisconsin earlier this year.

He was a member of the Baltimore County Medical Association, the Maryland State Medical Society, the American Medical Association, and was a charter member of the section on Administrative Psychiatry of the American Psychiatric Association.

He is survived by his widow, Hazel.

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USUAL ADULT DOSAGE: 1 or 2 capsules 3 or 4 times a day.
SIDE EFFECTS: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use are infrequent and consist principally of mild nausea and abdominal cramps.
Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.
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CAUTION: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken. Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.
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OFFICIAL CALL FOR *Scientific Exhibits*

1962 Annual Meeting, Milwaukee, May 8–9–10

★

THE Commission on Scientific Medicine is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1962 Annual Meeting. The exhibits will be located in Bruce Hall of the Milwaukee Auditorium.

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space at the 1962 meeting are requested to file an application BEFORE JAN. 1, 1962, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed.

In-state exhibitors will have the following facilities provided by the State Medical Society: Velour booth, electrical connection, shelving or tables, and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, special lighting equipment, and half the cost of any drapes rented (rented through Badger Flag and Decorating Company at time exhibit is installed).

Booths for scientific exhibits will have dark maroon velour background, 8′ in height, and 8′ velour side dividers (such as is shown in illustration at right).

No exhibit may exceed a height of 7′ from the floor.

Counters (3′ high and 20″ wide) or tables (30″ high and 3′ wide) are available for viewboxes or displays to be raised above floor level.

Spaces can be allocated in 10′ units.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit by Jan. 1, 1962. *No applications can be accepted after that date.* Address your communications to:

P. T. BLAND, M.D.
Director of Scientific Exhibits
% State Medical Society of Wisconsin
Box 1109
Madison 1, Wisconsin

Use form on following page.

APPLICATION

For Participation in the Scientific Exhibit

1962 ANNUAL MEETING **MILWAUKEE** **MAY 8-9-10**

★

Fill out the following information and mail to:

P. T. BLAND, M.D., *Director of Scientific Exhibits*
State Medical Society of Wisconsin
Box 1109, Madison 1, Wisconsin

1. Title of exhibit: _____

2. Description of exhibit (space allowed below for 200-word description): _____

3. The standard booth is 10′ wide and 9′ deep. What is the *minimum* space your display will require? 10′ 20′ 30′ (Circle One)
   (Space is scarce so do not request more than is necessary).

In figuring space, bear in mind you can use up to 8′ on each side in addition to back wall space of 10′ (less than 8′ if your display fills the entire back wall width).

4. Will radiologic viewing boxes be used? If so, will you furnish them? _____
   (The State Medical Society does not have equipment of this character available).

5. Name of exhibitor: _____

6. Name of institution cooperating in exhibit: _____

RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Madison April 14, 1961 (except for those indicated on other dates: *issued March 14, 1961; **issued February 2, 1961; and ***issued January 10, 1961).

Name	*School of Graduation*	*Year*	*City*
Archer, R. H.	University of Cincinnati	1952	Madison
*Arnaud, Sara	New York Medical College	1956	Milwaukee
Barber, K. E.	University of Chicago	1924	Chicago, Illinois
Beirne, G. J.	Stritch School of Medicine	1958	Madison
Bobowski, Celina	University of Pilsudski (Poland)	1940	Cincinnati, Ohio
**Bottum, M. W.	Marquette University	1959	Wood
Brose, Merle	University of Wisconsin	1946	Irwin, Pennsylvania
Cohen, Ellen	University of Illinois	1953	Rochester, Minnesota
Cooper, H. G.	University of Birmingham	1950	Duluth, Minnesota
Denby, J. L.	Duke University	1960	Milwaukee
Depner, R. J.	Duke University	1932	Milwaukee
DeVault, Marion	University of Kansas	1950	Milwaukee
*Enzinger, J.	University of Vienna	1949	Park Falls
Feinberg, M. W.	University of Illinois	1958	Skokie, Illinois
Fruchtman, M. Z.	University of Minnesota	1956	Oak Park, Michigan
Gedge, S. W.	Albany Medical College	1955	Marshfield
Hathaway, W. R.	Marquette University	1956	Neenah
Haverback, C. Z.	Johns Hopkins University	1955	Madison
Hitselberger, J. F.	Johns Hopkins University	1956	Fond du Lac
Hoelscher, F.	University of Frankfurt (Germany)	1947	Milwaukee
Hoops, H. J.	Columbia University	1954	Wood
Jackson, E. B.	Queen's University (Ireland)	1957	Independence, Iowa
Liberman, D. L.	University of Illinois	1918	Milwaukee
Moore, P. T.	Harvard Medical School	1938	Great Lakes, Illinois
Peden, K. K.	University of Edinburgh (England)	1959	Owen
Pemberton, H. W.	George Washington University	1952	Rockford, Illinois
Petereit, M. F.	University of Nebraska	1959	Fargo, North Dakota
***Rammer, M. A., Jr.	University of Wisconsin	1959	Madison
Reeds, R. E.	University of Iowa	1956	St. Paul, Minnesota
Rupple, J. H.	Wayne University	1959	Chicago, Illinois
Ryan, J. V.	Loyola University	1959	Chicago, Illinois
Sackin, H. D.	University of Toronto (Canada)	1955	Milwaukee
Schatzki, P. F.	Tufts University	1952	Milwaukee
**Sella, J.	Marquette University	1956	Mt. Calvary
Wardlaw, J. L.	New York University	1941	Madison
Whiteway, R. E.	Northwestern University	1946	Oak Park, Illinois

SPECIALISTS AND GENERAL PRACTITIONERS

Available through Placement Service

The Placement Service of the State Medical Society has registered with it a number of specialists in various fields as well as general practitioners. Contact the Placement Service by writing Box 1109, Madison, Wisconsin.

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MEDICAL MEETINGS—POSTGRADUATE COURSES

Medical Continuation Courses, Minnesota

Medical continuation courses to be presented at the Center for Continuation Study, University of Minnesota, Minneapolis, Minnesota are as follows:

Jan. 2–6: Intermediate Electrocardiography for General Physicians and Specialists

Jan. 25–27: To be announced.

Feb. 12–14: Pediatric Neurology

Mar. 5–7: Anesthesia for Specialists

Mar. 16–17: Treatment of Traumatic Injuries

Apr. 12:14: Otolaryngology for General Practitioners

Apr. 16–18: Internal Medicine for Internists

Apr. 26–28: Surgery for Surgeons

Apr. 30–May 2: Gynecology for General Physicians

North Shore Hospital Seminars

The second lecture in the North Shore Hospital Seminars of 1961–1962 on "Mental Hygiene" will be held at the hospital in Winnetka, Ill., on Wednesday, January 10, 1962, at 8 p.m. "The Challenge of Social Reacceptance—Mental Hygiene of the Ex-Psychiatric Patient" will be presented by Dr. Vladimir G. Urse, Superintendent of the Cook County Mental Hygiene Clinic.

General Practice Review in Denver

An annual postgraduate course designed especially for the general practitioner will be held January 7–13, at Denver, Colorado, by the University of Colorado School of Medicine. Details can be obtained by writing The Office of Postgraduate Medical Education, The U. of C. School of Medicine, 4200 East Ninth Avenue, Denver 20, Colo.

Circuit Teaching Program

Forthcoming circuit teaching programs will be held in January and February at Viroqua, Portage, Delavan and Oconomowoc. A project of the CES Foundation of the State Medical Society, these programs are co-sponsored by the Wisconsin Academy of General Practice, Wisconsin State Board of Health, Wisconsin Heart Association, American Cancer Society (Wisconsin Division), Wisconsin Anti-Tuberculosis Association, and the Postgraduate Program of Merck Sharp & Dohme.

On January 31, the program will be held in Viroqua at the Vernon County Memorial Hospital; and on February 1, it will be held at the Elks Club

WISCONSIN CALENDAR COMING EVENTS

1962

Jan. 4: Half-day course in dermatology, UW, Wisconsin Center building, Madison.

Jan. 18–20: Postgraduate course on Problems and Perspectives in Medicine, Wisconsin Center building, Madison.

Jan. 31: Circuit teaching program, SMS, Vernon County Memorial Hospital, Viroqua.

Feb. 1: Circuit teaching program, SMS, Elks Club, Portage.

Feb. 1: Half-Day course in pediatrics, UW, University Hospital, Madison.

Feb. 21: Circuit teaching program, SMS, Village Inn, Delavan.

Feb. 22: Circuit teaching program, SMS, American Legion Club, Oconomowoc.

Mar. 8: Half-day course in orthopedics, UW, University Hospital, Madison.

Apr. 5–7: UW postgraduate course, Genetics in Pediatrics, Drs. J. Crow and N. Smith, co-chrm., Wisconsin Center Building, Madison.

Apr. 12: Half-day course in gynecology—obstetrics, UW, University Hospital, Madison.

Apr. 26–28: UW postgraduate course, Psychosomatic Medicine, Dr. David Graham, chrm., Wisconsin Center Building, Madison.

May 3: Half-day course in therapeutics, UW, University Hospital, Madison.

May 8–10: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 10–11: UW postgraduate course, Orthopedic Surgery, Dr. H. Wirka, chrm., Wisconsin Center Building, Madison.

May 17–19: UW postgraduate course, Anatomy, Physiology and Pathology of the Holocrine, Apocrine and Eccrine Glands, Dr. S. Johnson, chrm., Wisconsin Center Building, Madison.

June 24–28: AMA Annual Meeting, Chicago, Illinois.

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California.

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

Intensive Postgraduate Courses

STARTING DATES—WINTER 1961–1962

Surgical Technic, Two Weeks, February 19
Surgery of Colon & Rectum, One Week, November 27
Surgical Board Review, Part II, Two Weeks, November 27
General Surgery, One Week, March 5
General Surgery, Two Weeks, December 11
Gynecology, Office & Operative, Two Weeks, April 9
Vaginal Approach to Pelvic Surgery, One Week, December 18, January 9
Obstetrics, General & Surgical, Two Weeks, November 27, March 12
Fractures & Traumatic Surgery, Two Weeks, March 5
Advances in Medicine, One Week, November 27
Practical Cystoscopy, Two Weeks, December 11, January 8
Proctoscopy and Sigmoidoscopy, One Week, December 18, January 29
Treatment of Varicose Veins, One Week, December 18, January 29
Clinical Courses, One Week or More, by appointment in.
Fractures, Orthopedics, Pediatrics, Dermatology, Diagnostic Radiology, Ophthalmology, Otolaryngology.

Teaching Faculty—Attending Staff of Cook County Hospital

ADDRESS: REGISTRAR, 707 South Wood Street
Chicago 12, Illinois

MEDICAL MEETINGS *continued*

in Portage. The session, from 2 until 5:30 p.m., will be presented by Drs. George E. Collentine, Gerald A. Kerrigan, and Burton A. Waisbren, all of Milwaukee, and associated with Marquette University School of Medicine. Subjects include: Overwhelming Sepsis, Newer Methods of Treating Burns, An Approach to Fluid and Electrolyte Problems, Hypothyroidism in Children, and New Antimicrobial Drugs.

The program in Delavan will be presented February 21 at the Village Inn and in Oconomowoc at the American Legion Club. This will be an afternoon session from 2 until 5:30. Dr. Edward A. Brucker, Jr., Madison pathologist, and Drs. Mischa Lustok and Anthony Pisciotta, of Milwaukee and Marquette University School of Medicine, will present the program which will cover the following topics: New Tests of Interest and Concern to the Generalist, Diagnostic Tests in Liver Disease, Medical Treatment of Arterial Hypertension, Treatment of Heart Failure and Its Complications, Iron Deficiency Anemia, and Megaloblastic Anemias.

Fee for each clinic is $4.00. AAGP credit of three hours of Category I will be given those attending. Reservations can be made by writing to the State Medical Society, Box 1109, Madison 1, Wis.

MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director

EUGENE FRANK, M. D.
WILLIAM C. JANSSEN, M. D
LOREN J. DRISCOLL, M. D.

JOSEF A. KINDWALL, M. D.
Consultant

LEROY A. WAUCK, Ph. D.
Clinical Psychologist

The Hospital is situated on the Nashotah Lakes, 30 miles west of Milwaukee, providing the ideal, restful country environment and the facilities for the modern methods of therapy of the psychoneuroses, psychosomatic disorders, alcoholism, and the other neurologic and psychiatric problems. Occupational therapy and recreational activities directed by trained personnel.

UW Postgraduate Course, Dermatology

A one-half day course in dermatology will be held January 4, 1962, at the University Hospital, Madison. The program is being planned by Dr. Sture A. M. Johnson. Subject of the course is Some Dermatologic Diseases Common in Medical Practice. Diagnosis and treatment will be discussed, with emphasis on new drug therapy.

New Orleans Graduate Medical Assembly

The twenty-fifth annual meeting of The New Orleans Graduate Medical Assembly will be held March 12, 13, 14 and 15, 1962, headquarters at The Roosevelt Hotel.

Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include 55 informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, medical motion pictures, round-table luncheons and technical exhibits.

Following the meeting in New Orleans, arrangements have been made for a clinical tour to the Eastern Mediterranean leaving New Orleans via air on March 16, to make a connection with jet flight leaving New York for Paris. The itinerary includes visits to Athens, Rhodes, Cairo, Luxor, Jerusalem and Tel Aviv, returning on April 6 to New York. (Optional extensions in Europe may be arranged).

Details of the New Orleans meeting and the tour are available at the office of the Assembly, Room 105, 1430 Tulane Avenue, New Orleans 12, Louisiana.

International Medical–Legal Society

The International Medical–Legal Society will conduct a seminar on February 17–24, 1962, in Honolulu, Hawaii. Details may be obtained by writing to the Society at 1206 South 11th Street, No. 17, Tacoma 5, Wash.

Postgraduate Course, Mayo Clinic

The Mayo Clinic and the Mayo Foundation are presenting a postgraduate course on Clinical Rheumatology on January 22, 23, and 24, 1962. The program will be held in Mann Hall in the Medical Sciences Building, Rochester, Minn.

The American Academy of General Practice and the Canadian College of General Practice will give credit to members attending the course.

The fee is $5 for registration and $55 for the course. The number of physicians who can be accommodated is limited. Those wishing to attend should communicate with M. G. Brataas, Secretary, Postgraduate Courses, Mayo Clinic-Foundation, Rochester, Minn.

The course should be of interest to both general practitioners and internists.

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Conference Headquarters—Roosevelt Hotel—March 12, 13, 14, 15, 1962

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Edward P. Cawley, M. D., Charlottesville, Va.
DERMATOLOGY

Julian M. Ruffin, M. D., Durham, N. C.
GASTROENTEROLOGY

Carroll L. Witten, M. D., Louisville, Ky.
GENERAL PRACTICE

Howard W. Jones, Jr., M. D., Baltimore, Md.
GYNECOLOGY

Thomas M. Durant, M. D., Philadelphia, Pa.
INTERNAL MEDICINE

Maxwell M. Wintrobe, M. D., Salt Lake City, Utah
INTERNAL MEDICINE

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NEUROLOGY

Ralph C. Benson, M. D., Portland, Ore.
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Victor A. Byrnes, M. D., St. Petersburg, Fla.
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PATHOLOGY

Lewis L. Coriell, M. D., Camden, N. J.
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Robert D. Moreton, M. D., Fort Worth, Tex.
RADIOLOGY

John H. Mulholland, M. D., New York, N. Y.
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Leaving March 16 via air and returning April 6, 1962
(Optional extensions may be arranged)

For information concerning the Assembly meeting and the tour write Secretary, Room 105, 1430 Tulane Ave., New Orleans 12, La.

Membership Report as of July 31, 1961

NEW MEMBERS

Rolla R. Wolcott, M.D., Phelps, Wisconsin
Francis Gilbert, M.D., 324 West Main Street, Waukesha, Wisconsin
Jack R. Hoffman, M.D., 2405 Indian Trail, Brookfield, Wisconsin
Henry B. Wengelewski, M.D., Veterans' Administration, Wood, Wisconsin

CHANGES OF ADDRESS

Louis M. Rosenheimer, M.D., to 845 North 22nd Street, Milwaukee, Wisconsin
Thomas Puchner, M.D., to 324 East Wisconsin Avenue, Milwaukee, Wisconsin
Paul J. Whitaker, M.D., to 13335 Gremoor Drive, Elm Grove, Wisconsin
Ralph E. Morter, M.D., to 1518 East Goodrich Lane, Milwaukee, Wisconsin
Robert J. Fritz, M.D., to 3535 West Oklahoma Avenue, Milwaukee, Wisconsin
Elvin Bremer, M.D., to 1212 West Wisconsin Avenue, Milwaukee, Wisconsin
Stephen A. Konz, M.D., to 650 West Foster Street, Appleton, Wisconsin
N. J. Lockowitz, M.D., to 6831 West Villard Avenue, Milwaukee 18, Wisconsin
R. B. Leitschuh, M.D., to 5100 Windpoint Road, Racine, Wisconsin
William C. Janssen, M.D., to 425 East Wisconsin Avenue, Milwaukee, Wisconsin
Mona Rose, M.D., to 425 East Wisconsin Avenue, Milwaukee, Wisconsin
John J. Arneth, M.D., to 2524 North 91st Street, Wauwatosa 13, Wisconsin
William A. Domann, M.D., to N86–W16686 Jacobson Drive, Menomonee Falls, Wisconsin
John R. Flanary, M.D., to 2437 North Harding Boulevard, Wauwatosa 13, Wisconsin
R. J. Russell, M.D., to 6131 West Wells Street, Wauwatosa 13, Wisconsin
G. H. Smullen, M.D., to 1911 Washington Street, Racine, Wisconsin
F. K. Dean, M.D., to 1313 Fitchburg Road, Madison, Wisconsin
James L. Dean, M.D., to 1313 Fitchburg Road, Madison, Wisconsin
William H. Bartlett, M.D., to 1313 Fitchburg Road, Madison, Wisconsin
Robert L. Beilman, M.D., 1313 Fitchburg Road, Madison, Wisconsin
Charles F. Burke, M.D., to 1313 Fitchburg Road, Madison, Wisconsin
Charles E. Hopkins, M.D., to 1313 Fitchburg Road, Madison, Wisconsin
Edward K. Ryder, M.D., to 1313 Fitchburg Road, Madison, Wisconsin
Robert X. Farrell, M.D., to 1313 Fitchburg Road, Madison, Wisconsin
Edwin F. Schneiders, M.D., to 1313 Fitchburg Road, Madison, Wisconsin
A. M. Sonneland, M.D., to 1313 Fitchburg Road, Madison, Wisconsin
William C. Mussey, M.D., to 1313 Fitchburg Road, Madison, Wisconsin
A. H. Heidner, M.D., to 1622 Chestnut Street, West Bend, Wisconsin
W. A. Nielsen, M.D., to 1622 Chestnut Street, West Bend, Wisconsin
R. C. Zastrow, M.D., to St. Michael Hospital, 2400 West Villard Avenue, Milwaukee 9, Wisconsin
James F. Baumgartner, M.D., to 1622 Chestnut Street, West Bend, Wisconsin
O. M. Wilson, M.D., to P. O. Box 838, Wausau, Wisconsin
W. W Stebbins, M.D., St. Petersburg, Florida, to 2121 West Lawn Avenue, Madison, Wisconsin
Charles R. Starr, M.D., Madison, to 365 Dogwood N. E., Ada, Michigan
Thomas E. Zabors, M.D, Milwaukee, to Box 2325, Los Angeles 53, California
Alexander J. Mac Gillis, M.D., Milwaukee, to 260 Grittenden Boulevard, Rochester, New York
Boyd F. Nirschl, M.D., Milwaukee, to 596 South Carroll Street, Sunnyvale, California
Michael W. Shutkin, M.D., Milwaukee, to Veteran's Administration Hospital, Sepulveda, California
George Flynn, M.D., Shorewood, to 324 East Wisconsin Avenue, Milwaukee, Wisconsin
William E. Reifenrath, M.D., Wauwatosa, to 4835 West Capitol Drive, Milwaukee, Wisconsin
Carl F. Schmidt, M.D., Milwaukee, to 1836 South Avenue, La Crosse, Wisconsin
William E. Mateicka, M.D., Sussex, to N59 W21962 Meadows Drive, Menomonee Falls, Wisconsin
Robert E. Carlovsky, M.D., Fond du Lac, to 1052 St. Paul Street, Denver, Colorado
Domenick S. Bruno, M.D., Milwaukee, to 206 South Whitney Way, Madison, Wisconsin
Stephen Dudiak, M.D., Racine, to 2913 Harrison Lane, Madison, Wisconsin
J. J. Mulvaney, M.D., Clintonville, to 2225 Indian Trail, Traverse City, Michigan
Capt. Sherwyn M. Woods, M.D., Madison, to USAF–MC, USAF Hospital, March AFB, California
George A. Berglund, M.D., Madison, to 7717 Geralayne Drive, Wauwatosa 13, Wisconsin
Lt. James R. Hanson, M.D., Madison, to U. S. Naval Hospital, Camp Pendleton, California
James H. Schultz, M.D., Jackson, to 1622 Chestnut Street, West Bend, Wisconsin
Martin A. Rammer, Jr., M.D., Madison, to 1706 Broadway, Sheboygan, Wisconsin

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1. Clark, T. E., and Jochem, G. G.: Angiology 11:361 (Aug.) 1960.

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

NEW BOOKS RECEIVED

THE HOUSE OF HEALING

The Story of the Hospital. By Mary Risley. Doubleday & Co., Inc., Garden City, New York, 1961. 288 pages. Price: $4.50.

ESSENTIAL HYPERTENSION

An International Symposium, Berne, Switzerland, June 7–10, 1960, sponsored by Ciba. Edited by K. D. Bock, and P. T. Cottier; Chairman, F. C. Reubi. Springer–Verlag, Berlin, Germany, 1960. 392 pages.

THE CARDIAC ARRHYTHMIAS

A Guide for the General Practitioner. By Brendan Phibbs, M.D., Casper Clinic, Casper, Wyoming. C. V. Mosby Co., St. Louis, Mo., 1961. 128 pages. Price: $7.50.

SYMPTOM DIAGNOSIS

By Wallace M. Yater, M.D., Director, Yater Clinic, Washington, D.C., and William F. Oliver, M.D., Assistant Clinical Professor of Medicine, University of Southern California School of Medicine. 5th Ed. Appleton–Century–Crofts, Inc., New York, 1961. 1035 pages. Price: $15.00.

BOOK REVIEWS

CELLULAR ASPECTS OF IMMUNITY

Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A. Little, Brown & Co, Boston. 1960. 495 pages. Price: $10.50.

This book is the report of the International Conference on the Cellular Aspects of Immunology, sponsored by the Ciba Foundation, which took place at the Abbey of Royaumont, France, on June 3–5, 1959. The United States was represented by F. Dixon, R. Good, T. Harris, H. Kunkel, J. Lederberg, E. Lederberg, R. T. Smith, and B. Waksman.

The entire set of papers gives a current summary of the subject presented by authorities in the field, ranging from antibody production theories to the study of autoimmune disease. Each paper was read by one or more of its authors and is printed with the conference discussion following it. Bibliographies for the papers are included after them, but that of the discussion is worked into the textual material. A few illustrations are used in the material when necessary.

A partial table of contents is as follows: Nomenclature of Immunologically Competent Cells—A. Fagraeus, Identification of Immunologically Competent Cells—M. Simonson, Theories of Immunological Tolerance—P. Medewar, discussion on the Clonal Selection Theory of Antibody Formation—M. Burnet and J. Lederberg, Formation of Antibodies in Vitro—P. Grabar and P. Corvazier, A Study of Serum Proteins Related to Immunity and Their Cellular Origins—P. Burtin, The Cellular Basis for the Immunological Memory—D. W. Dresser and N. A. Mitchison, Response to Active Immunization of Human Infants During the Neonatal Period—R. T. Smith, and Multiple "Autoantibodies" to Cell Constituents in Systemic Lupus Erythematosis—H. G. Kunkel, H. R. Holman, and H. R. G. Deicher.

This book would be of immense value to Immunologists, Immunopathologists, and others interested in the field of Immunology as a summary of the state of the art to the date of the book's appearance.—Byron A. Myhre, M.D.

CURRENT MEDICAL REFERENCES

Edited by Paul J. Sanazaro, M.D., Associate Professor of Medicine, University of California School of Medicine, San Francisco, California. Lange Medical Publications, Los Altos, California. 1959. 535 pages. Price: $3.50.

This handbook published in 1959 provides a list of references of the literature for a large variety of headings of symptoms and diseases. The arrangement lists references under subheadings in many instances as well. For example, under angina pectoris there are 5 references under General, 11 under Treatment, 3 under Prognosis. In many instances the editors comment in a sentence or two on the reference cited and list the number of additional references in the article referred to. They indicate that they have tried to compile some of the most useful references of the past twenty years in clinical medicine for the student and practitioner, and they have tried to select references which are available in the average modern hospital library. They have succeeded in their objective fairly well, and this small book may be handy for the busy person, but it cannot be looked upon as a good substitute for the actual visit to the library and the seeking of references from the indexes available there that list the world literature annually, semi-annually or more frequently.—O. O. Meyer, M.D.

THE THYROID–VITAMIN APPROACH TO CHOLESTEROL ATHEROMATOSIS AND CHRONIC DISEASE; A TEN-YEAR STUDY

By Murray Israel, M.D. The George Press, Inc., New York, N.Y. 1960. 132 pages.

Hogwash.—E. C. Albright, M.D.

drugs anonymous

One of the several hastily conceived and potentially dangerous suggestions for reducing drug costs is generic-name prescribing. The proponents of generic-name prescribing claim that it will lower drug costs significantly and—through supervision by the Federal Government—provide quality equivalent to that of trademarked drugs. We maintain that these claims are false. Here are some authoritative answers to the principal questions posed by generic-name prescribing.

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Rhode Island Medical Journal,
January, 1961

Are the savings worth the risk of sacrificing quality?

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Lloyd C. Miller, Ph. D.
Director of Revision of the U.S.P.

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Albert H. Holland, M.D.
formerly Medical Director of the
Food and Drug Administration

Smith Kline & French Laboratories, Philadelphia

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the Wisconsin Medical Journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

VOL. 60, NO. 12—DECEMBER 1961

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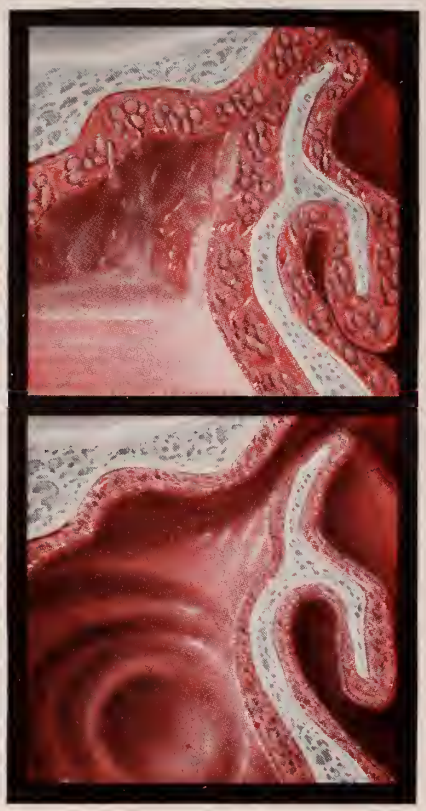

The clogged sinus
In sinusitis, the mucous membrane becomes hyperemic and edematous, lymph glands and goblet cells hyperactive. Ostium is closed by edema and secretions cannot drain freely.

The normal sinus
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1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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LETTERS OF INTEREST

MEDICAL ASSISTANTS SOCIETY

To SMS:

The newly-elected officers of the Wisconsin State Medical Assistants Society were installed at the conclusion of their 7th Annual Convention held at the Avalon Hotel in Waukesha June 3–4, 1961. They were: president, Mrs. Julia Logerquist (Dr. Dan Dorchester, Sturgeon Bay), president-elect, Mrs. June Gillette (Drs. Mooney and Houfek, Sheboygan), recording secretary, Miss Shirley M. Kallas (Dr. Miles B. Smith, Milwaukee), corresponding secretary, Miss Catherine Moog (Dr. J. B. Wilets, Milwaukee) and treasurer, Mrs. Lucille Skolaski (Dr. R. F. Collins, Madison).

Keynote speaker at the convention was Dr. Carl S. Winters, world-renowned lecturer and humorist. His subject was "The Key to Understanding." Doctor Winters was presented through the courtesy of the General Motors Corporation. Mr. John Lehrer, public relations director of the Mayfair Shopping Center, Milwaukee, presented "The Key to Service." "The Key to Persuasion" was the topic of Dr. Joseph Bartos, Waukesha. Mrs. Mercedes Chalmers, educational director of the Patricia Stevens School of Charm, Milwaukee, discussed "The Key to Charm." Convention chairman was Mrs. Aleen Piepenberg, Waukesha. Mrs. Mildred Gedakovitz, Waukesha, is immediate past president.

(Miss) Shirley M. Kallas
Publicity Chairman
Wisconsin State Medical Assistants Society

AN ASSIST IS ALWAYS WELCOME

To SMS:

Your Automotive Crash Injury Research Program is greatly needed and I will assure you that I will do everything possible to help.

My interest lies particularly in the drinking driver who is apparently responsible for most of the serious accidents. In 1932 when I published my first paper on the importance of alcohol in automotive accidents, Mr. Matthews, of the State of Pennsylvania, reported in 1930 that alcohol played a part in 1% of the fatal accidents in Pennsylvania whereas a survey that I performed indicated that alcohol played an important part in over half of the accidents involving injury or death. It is therefore extremely important that every person who dies in a motor vehicle accident, whether he be a pedestrian or driver, be tested for alcohol.

Herman A. Heise, M.D.
425 East Wisconsin Avenue
Milwaukee 2, Wisconsin

A MUTUAL FEELING

To DOCTOR GOLDSTEIN:

Dr. W. D. Snively, Jr., has shown me your editorial, "Welcome Assist," in the *Wisconsin Medical Journal* (July 1961). This is just to tell you how much I enjoyed seeing it. You have certainly expressed very well the feeling that we physicians at Mead Johnson & Company have toward this project.

Louis F. Rittelmeyer, Jr., M.D.
Vice President, Medical Director
Mead Johnson & Company
Evansville 21, Indiana

FROM CALIFORNIA TO MAINE

To DOCTOR SHAPIRO (Secretary, Crawford County Medical Society, Prairie du Chien):

When Dr. Donald A. Charnock, the Chairman of our Library Committee, returned from the American Medical Association National Meeting in New York, he brought to us the William Beaumont medallion with the compliments of your Museum of Medical Progress. On behalf of the Library Staff I express our thanks for this worthwhile addition to our modest numismatic collection.

At the same time I wish to acknowledge the receipt in the mail last week of your circular describing your program and activities. Do you have any catalog or list of instruments in your collection? Specifically do you have any of the earlier instrumentation in the field of anesthesiology? If so I would be interested in more detailed information.

In the meantime, every success in this ambitious undertaking.

John M. Connor
Librarian
Los Angeles County Medical Association

To DOCTOR STOVALL:

Congratulations on the Museum of Medical Progress, most appropriately placed at Prairie du Chien. I hope you have had a successful summer with many visitors. Let me have further reports and literature.

Henry R. Viets, M.D.
East Boothbay, Maine

TO DOCTOR STOVALL:

I appreciate very greatly your kindness in sending me your little letter announcing the end of the first full year of operation of the Museum of Medical Progress. I am happy to have your most excellent brochure and to learn of this project. I wish you all success in this endeavor and shall certainly visit you when an opportune occasion arises.

Elmer Belt, M.D.
1893 Wilshire Boulevard
Los Angeles, California

TO DOCTOR STOVALL:

It is a great pleasure indeed to learn about creation of the Museum in the restored military hospital of the 2nd Ft. Crawford, at Prairie du Chien. I shall look forward to seeing it. My congratulations on a fine tribute to Doctor William Beaumont in your Museum of Medical Progress.

I cherish some personal associations with Wisconsin. My great grandfather was a pioneer settler near Waukesha over a century ago. As a child I first lived at Winona, Minnesota and later at Stevens Point, Wisconsin.

Uncles of mine were horse and buggy country doctors in Minnesota and then Model-T Ford took over as transportation. As a small child I rode with them many miles over the dirt roads, as they made their calls. So your folder brings back many memories.

Of recent years I've seen primitive conditions again during medical educational surveys in the Far East, Middle East, and yes, in the country too! Best wishes for your project.

J. A. CURRAN, M.D.
Bingham Associates Fund
171 Harrison Avenue
Boston 11, Massachusetts

WORKMEN'S COMPENSATION

TO DOCTOR LOKVAM:

It affords me considerable pleasure in being permitted to acknowledge the resolution adopted by your association on May 3, 1961, commemorating the Golden Anniversary of Workmen's Compensation in Wisconsin. The commission is deeply grateful to be informed regarding the sentiments of the State Medical Society toward the Workmen's Compensation Law. Members of your profession have been of material assistance to this commission in carrying out our responsibilities established by our Workmen's Compensation Law.

Your members have rendered a yeoman service in not only treating those workmen in the state involved with disabilities coming within the provisions of our W. C. law, but having them return to work as soon as their physical conditions permit, and several times with little or no resulting permanent disability. You have cooperated in attempting to maintain an open panel system for the treatment of W. C. claims, and helped to promulgate working tools which have been of material assistance to this commission in carrying out its duties under the law.

In connection with the latter I have in mind the four medical formulae which have been of material benefit in adhering to the principals intended by our Workmen's Compensation Law. Perhaps brief mention should be made of the unsatisfactory conditions which prevailed prior to 1911 with regard to the adjudication of claims for recovery of benefits resulting from the employment disabilities. The first medical formula adopted by the commission relates to the adjudication of compensation benefits resulting from eye injuries; the others in the following order; the relative permanent disability rating schedule; the occupational loss of hearing schedule; and the diagnostic procedure for Brucellosis. The doctors of the state were extremely helpful in working out the foregoing procedure.

The foregoing has been largely responsible for reducing the number of controverted claims in the state and is followed by the payment of compensation benefits pursuant to the statutory provisions in approximately 90 per cent of the total claims within the state. They have been the means of avoiding unnecessary delay, certainty for uncertainty, and materially eliminating unnecessary litigation expense which the workers generally cannot afford to pay. These represent only a few of the contributions made by members of your society and this commission is duly grateful for this cooperation and assistance without having incurred any cost to the taxpayers in the state.

R. G. KNUTSON
Commissioner
Industrial Commission
1 West Wilson Street
Madison, Wisconsin

THANKS FROM 4-H CLUBS

TO STATE MEDICAL SOCIETY:

Our 4–H Club, the McFarland 4–H of McFarland, wishes to thank you for the twelve month subscription to *Today's Health*. We have already received three copies and we are using them for references for health talks at our meetings. We think the talks are on many more subjects by using this material. Our organizational leader, Mrs. Erling Olson, brings them to the meeting and different members take them home each month.

JUDITH OLSON
Reporter
McFarland 4–H Club

TO STATE MEDICAL SOCIETY:

As the Health–Safety Jr. Leader of the Cicero Busy Bees 4–H Club of Outagamie County, I wish to thank you for the twelve month subscription of the *Today's Health* magazine which was awarded to our club for their achievements in the Health–Safety Program.

Our members and leaders enjoy working cooperatively in this specific field and they hope to continue their work to influence more of our citizens, to promote health and safety.

We are very grateful to have wonderful donors and sponsors such as you to give our youth organizations the support which they need. Thank you for your fine cooperation. We do appreciate it.

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1 Graham, Sotto and Paloucek—Cancer of the Cervix

A New Book!--Up-to-date and authoritative coverage of cervical carcinoma

This authoritative new monograph, from the world-famous *Roswell Park Memorial Institute*, brings you today's latest information on the diagnosis and management of cervical cancer. The authors begin with an interesting discussion of the frequency, etiology and pathology of such lesions. There are extensive sections on diagnosis and therapy — including complications affecting management such as *pregnancy, prolapse of the uterus, carcinoma of a cervical stump, and fever.* You'll find fully illustrated coverage of techniques of obtaining material for Papanicolaou smears and performing cervical biopsy. Both irradiation and operative techniques are explained and illustrated in detail.

By John B. Graham, M.D., Chief Gynecologist; Luciano S. J. Sotto, M.D., formerly Attending Gynecologist; and Frank P. Paloucek, M.D., Attending Gynecologist. All of the Roswell Park Memorial Institute, Buffalo, New York. About 544 pages, 6½"x9¾", with 157 illustrations. About $15.00. *New—Ready in January!*

2 Hogan and Zimmerman—Ophthalmic Pathology

New (2nd) Edition!--A superb atlas and textbook on the eye and its disorders

In a straightforward and visually superb manner, this book clearly sets forth the morphologic pathology of the eye and the physiologic processes affecting ocular change. The authors first cover principles of general pathology, pathologic entities affecting the entire eye, and a general discussion of ocular injuries. Anatomy, histology, congenital and developmental anomalies, inflammations, metabolic disorders, neoplasms are then carefully considered for all the various regions of the eye: *the lids and lacrimal drainage apparatus, the cornea and sclera, the uveal tract, retina, optic nerves, vitreous, and the orbit.* Many beautiful new illustrations have been incorporated.

Edited by Michael J. Hogan, M.D., Professor and Chairman, Department of Ophthalmology, University of California School of Medicine, San Francisco; and Lorenz E. Zimmerman, M.D., Chief, Ophthalmic Pathology Branch and Registrar, Registry of Ophthalmic Pathology, Armed Forces Institute of Pathology, Washington, D.C.; with 15 Contributors. 797 pages, 7½"x11", with 703 figures, some in color. About $30.00. *New (2nd) Edition!*

3 Owen—Hospital Administration

A New Book!--A complete and much needed source book on managing today's hospitals

The place of the hospital in the community and the interrelationships between departments of the hospital are clearly set forth in this new day-to-day reference source. Here you will find hundreds of valuable ideas to help increase efficiency in the construction, organization and administration of today's hospitals. Every aspect of administration is carefully detailed from *Planning and Organizing the Hospital* to *Hospital Law*. There is valuable coverage of: *Financial Management — Laundry and Linen Service — Maintenance of Building and Grounds—Organizing the Medical Staff—Surgical Services—Medical Record Library — Chaplaincy Service — Public Relations—Research—Trusteeship.*

Edited by Joseph Karlton Owen, B.S., M.S., Ph.D., Specialist in Hospital Administration, Louis Block and Associates, Inc., Silver Spring, Md.; with the Coordinative Assistance of Robert K. Eisleben, B.A., M.A., Assistant Administrator of Little Company of Mary Hospital, Torrance, Calif. About 960 pages, 6½"x9¾", with 186 illustrations. About $16.00. *New—Ready in January!*

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LETTERS OF INTEREST *Continued*

TO STATE MEDICAL SOCIETY:

We, the Merry Maids 4–H Club and leaders, wish to thank you very much for our Health Achievement Award and the year subscription to the Health Magazine. We received it last year and all our club members and leaders enjoyed it very much. We also used it as a speech and health talk background for our club. So again, thanking you very much for your kindness and feeling toward 4–H. Without you good people we wouldn't have many of these nice things.

MARY LYNN HUTJENS
Health Junior Leader
Merry Maids 4–H Club
De Pere, Wisconsin

FOREIGN MISSION FIELD

TO MR. CROWNHART:

During the Annual Meeting this year, the AMA House of Delegates approved a plan to cooperate in the recruitment of volunteer physicians for emergency service in the foreign mission field.

The Department of International Health is seeking the names of physicians who will volunteer to serve in the mission field on a temporary basis. We are receiving the cooperation of agencies representing every religious denomination in the U. S. which sponsors medical missionaries.

Each physician who volunteers will be asked to complete the attached application form. This information will be used by the missionary agencies in considering the qualifications of the applicant. The final choice as to the acceptability of each volunteer physician rests with the screening committees of the missionary agency.

We shall appreciate your cooperation in informing the members of your society about this new AMA program. Physicians who are interested should write directly to the Department of International Health.

If we can provide any additional information, please do not hesitate to let us know.

F. J. L. BLASINGAME, M.D.
Executive Vice-president
American Medical Association
535 North Dearborn Street
Chicago, Illinois

EDITOR'S NOTE: *If you have received any letters which might be of interest to your colleagues or the Society, they will be welcome for this section of the Journal. Forward the letters to: Editor,* WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison 1, Wisconsin.*

COUNTY SOCIETY PROCEEDINGS

BARRON–SAWYER–WASHBURN–BURNETT

Members of the Barron–Sawyer–Washburn–Burnett County Medical Society heard John R. Cameron, Ph.D., Madison, talk on radioactivity at the November 14 meeting held in Rice Lake. Doctor Cameron, assistant professor of radiology at the University of Wisconsin Medical School, appeared through sponsorship by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from Merck Sharp & Dohme.

BROWN

Forty-five members of the Brown County Medical Society met November 9 at the Elks Club in Green Bay. Following dinner the group heard Mr. Colburn Cherney talk on "Your Estate and Your Future" and Mr. Glen Macaux, an insurance underwriter, discuss life insurance.

During the business meeting *Dr. E. R. Killeen*, president, Green Bay, announced the members of the newly formed TV committee. *Dr. M. D. Blackburn*, Green Bay, is chairman. This committee will provide a half-hour program every third Sunday on Channel 5. The programs will include medical information of interest to the public. The first program was on "Tonsils and Adenoids" presented November 19. *Drs. W. W. Ford*, Green Bay; *S. L. Griggs*, Green Bay; and *W. Mac Mullen*, Green Bay, conducted the program. The second program was presented on December 10 on the subject of "Breast and Cervical Cancers and Papanicolaou Smears."

Dr. L. Edelblute, Green Bay, was named chairman of the Boy Scout Explorers' Post which may be organized for projects related to medicine.

Dr. K. L. Zucker, Green Bay, gave a report on the Twelfth Medical Societies Conference on Disaster Medical Care sponsored by the Council on National Security, American Medical Association, which was held November 4–5 in Chicago.

Dr. John R. Goelz, Green Bay, was named chairman of the newly created radio committee. This committee will arrange programs on medicine for radio station WBAY.

CHIPPEWA

Dr. H. H. Shapiro, Madison, was guest speaker at the November 7 meeting of the Chippewa County Medical Society. Doctor Shapiro, clinical professor of medicine at the University of Wisconsin Medical School, talked on "Electrocardiography." The meeting was held at Reeters Steak House in Chippewa Falls. Doctor Shapiro's appearance was sponsored by the CES Foundation of the State Medical Society under a grant from the Wisconsin Heart Association.

New officers for the coming year are as follows:

President—*Dr. D. A. Sallis*, Boyd
Vice-president—*Dr. C. Kemper*, Chippewa Falls
Secretary-treasurer—*Dr. G. Shonat*, Chippewa Falls
Delegate—*Dr. M. Asplund*, Bloomer
Alternate—*Dr. J. J. Sazama*, Chippewa Falls

GREEN LAKE–WAUSHARA

Members of the Green Lake–Waushara County Medical Society heard *Dr. Ben R. Lawton*, Marshfield, discuss "Treatment of Chest Injuries" at their October 26 meeting held at the Whiting Hotel in Berlin. Doctor Lawton, who is a surgeon at the Marshfield Clinic, was sponsored by the CES Foundation of the State Medical Society under a grant from Merck Sharp & Dohme.

JEFFERSON

Members of the Jefferson County Medical Society heard *Dr. Henry Peters*, Madison, talk on "Porphyrin" at their November 16 meeting held at the Meadow Springs Country Club in Jefferson. An associate professor of neuropsychiatry at the University of Wisconsin Medical School, Doctor Peters' appearance was sponsored by the CES Foundation of the State Medical Society under a grant from Merck Sharp & Dohme.

LA CROSSE

Fifty-six members of the La Crosse County Medical Society met October 23 at the Fireside Restaurant in La Crosse. *Dr. John Allen*, Madison, was guest speaker. He appeared on behalf of the Department of Public Welfare and talked on rehabilitation of the chronically ill, the use of generic drugs, and the use of advisory committees to local welfare departments.

It was announced that the Adolf Gundersen Memorial Lecture would be held on November 16. A poll of the La Crosse County Medical Society membership concerning smoking was taken for the Wisconsin Division of the American Cancer Society.

New members accepted by the Society are: Dr. Stephen C. Copps, La Crosse; *Dr. Robert E. Whiteway*, La Crosse; *Dr. Carl F. Schmidt*, La Crosse. Doctor Whiteway transferred from the Chicago County Medical Society and Doctor Schmidt, from the Milwaukee County Medical Society.

OCONTO

New officers of the Oconto County Medical Society, elected at the November 21 meeting, are as follows:

President—*Dr. H. A. Aageson*, Oconto
President-elect—*Dr. G. R. Sandgren*, Suring
Secretary—*Dr. F. Klutzow*, Gillett
Delegate—Dr. H. A. Aageson, Oconto
Alternate—*Dr. J. R. Culver*, Oconto Falls

Physicians whose names appear in italic are members of the State Medical Society.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

RACINE

At the November meeting of the Racine County Medical Society the following officers were elected:

President—*Dr. Frank M. Hilpert*, Racine
President-elect—*Dr. Warren H. Williamson*, Racine
Vice-president—*Dr. Ernest L. MacVicar, Jr.*, Racine
Secretary—*Dr. Frank J. Scheible*, Racine
Treasurer—*Dr. L. E. Jones*, Racine

Named to the executive committee were *Dr. Richard J. Mayer*, Racine, and *Dr. William J. Madden*, Racine. *Dr. Richard J. Fogle*, Racine, was named to the board of censors. *Dr. Louis E. Fazen, Jr.*, Racine, and *Dr. G. L. Rothenmaier*, Racine, were elected delegates to the State Society and *Dr. Vernon J. Burch*, Racine, and *Dr. William F. Henken*, Racine, were elected as alternate delegates.

The annual Christmas dinner-dance was held December 5 at the Racine Country Club. Dr. and Mrs. Frank Hilpert entertained at a pre-dinner reception.

ROCK

The Rock County Medical Society met at the Hilton Hotel in Beloit on October 24. Dr. Melvyn Bayley, professor of obstetrics and gynecology at Northwestern University Medical School, spoke on "Abnormal Uterine Bleeding."

This was also the annual meeting for election of officers. The following were elected:

President—*Dr. Eugene Betlach*, Janesville
Vice-president—*Dr. R. M. Baldwin*, Beloit
Secretary-treasurer—*Dr. W. A. Scholten*, Beloit
Delegates—*Dr. M. D. Davis*, Milton; *Dr. D. M. Clark*, Beloit
Alternates—*Dr. M. F. Purdy*, Janesville; *Dr. J. C. Beltran*, Beloit

SAUK

Dr. Maxine Bennett, Chairman of the Department of Otolaryngology of the University of Wisconsin Medical School, Madison, was guest speaker at the November 14 meeting of the Sauk County Medical Society which met at the Warren Hotel in Baraboo. Her subject was "The Deaf Child and Evaluation of Hearing Problems."

SHEBOYGAN

At the quarterly session of the Sheboygan County Medical Society on October 26 *Dr. H. A. Weisse*, president, Sheboygan, appointed a three-member committee to work with the Sheboygan County Welfare Council in bringing about a county health department. Named chairman of the committee was *Dr. Lloyd M. Simonson*, Sheboygan, with *Drs. L. J. Steffan*, Plymouth, and *James L. Weygandt*, Sheboygan Falls, members.

In other action, physicians were instructed to contact Wisconsin representatives in Congress to support the Kerr–Mills Act for care of the elderly.

Dr. Earl H. Jochimsen, psychiatrist member of the Sheboygan Clinic, was elected into membership.

Mr. Verne Read, vice-president of the T. A. Chapman Co., Milwaukee, was guest speaker. He narrated films taken on a 400-mile inflated raft trip on the Colorado River through the Grand Canyon. Of special interest to the physicians was Mr. Read's comments on improvised medical care he received after falling 50 feet during the trip, sustaining a skull fracture and two broken vertebrae.

WINNEBAGO

A dinner meeting of the Winnebago County Medical Society was held October 26 at the Athearn Hotel in Oshkosh. Guest speaker was Dr. R. T. Mattingly of the Marquette University School of Medicine, Milwaukee. His subject was "The Use of Steroids in Obstetrics and Gynecology."

SMS ANNUAL MEETING

MAY 8–9–10, 1962

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the number of hours he worked, it would not be much more than the average plumber's income.

Doctor Annis said the answer to good medical care is private insurance, and this is what we have to get across to the public. Statistics show, he said, that most people care more for their automobile than they do for complete medical coverage.

Dr. Charles J. Picard, left, Superior, is shown above receiving the plaque and congratulations from Dr. Robert F. Purtell, Milwaukee, on behalf of the membership of the WAGP. A resolution passed by the Congress of Delegates during the annual meeting cited Doctor Picard for his many years of faithful service to the Academy as a director, president, and chairman of the Board.

During the business session the Congress of Delegates passed resolutions urging the Wisconsin legislature to implement the Kerr–Mills Act; commending the A.M.A. on its stand on Division of Fees; calling for a study of Blue Shield plans to provide more medical as well as surgical benefits; praising the tory-motivated, private professional organi- Wisconsin Legislature for passing a law requiring seat belts in all 1962 automobiles sold in Wisconsin; commending Marquette University School of Medicine and its dean, *Dr. John S. Hirschboeck*, for its family care program; and commending *Dr. Charles J. Picard*, Superior, outgoing chairman of the Board of Directors, for his many years of faithful service to the Academy of General Practice and the medical profession.

New officers of the Academy, elected at this meeting, were reported in the October issue.

Milwaukee Academy of Medicine

The October 17 meeting of the Milwaukee Academy of Medicine was held at the University Club of Milwaukee. Guest speaker was Dr. Henry N. Wagner, Jr., of the Department of Medicine, Johns Hopkins University School of Medicine. His subject was "The Current Status of Nuclear Medicine."

Theodore T. Puck, Ph.D., Professor and Chairman, Department of Biophysics, Department of Medicine, University of Colorado, was the guest speaker at the November 21 meeting. His subject was "The Human Chromosomes."

Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology

Members of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology met September 16 and 17 at Bailey's Harbor for a business and scientific program.

The scientific program included:

"Some Sources of Error in Neuro-Ophthalmology" by Dr. C. Wilbur Rucker, Mayo Clinic, Rochester, Minn.

"Rhinoplasty and Problems of the Septum" by Dr. Oscar J. Becker, University of Illinois, Chicago, Ill.

"History of Spectacles" by Dr. C. W. Rucker.

"Surgical Correction of Protruding Ears" by Dr. Oscar J. Becker.

"Sources of Error in Diagnosis of Optical Chiasmal Lesions" by Dr. C. W. Rucker.

Milwaukee Oto-Ophthalmic Society

The annual social meeting of the Milwaukee Oto-Ophthalmic Society was held November 28. Guest speaker was Dr. Eugene L. Derlacki, associate clinical professor, Northwestern University Medical School, Chicago, Ill.

Wisconsin Society of Pathologists

The Wisconsin Society of Pathologists elected the following officers at its meeting October 20 in Milwaukee:

President—*Dr. Frank J. Glassy* (1962), Marshfield

Vice-president—*Dr. David J. Carlson* (1962), Milwaukee

Secretary—*Dr. Robert S. Haukohl* (1960–1962), Milwaukee

Treasurer—*Dr. Chesley P. Erwin* (1961–1963), Milwaukee

Delegate to SMS—*Dr. Joseph L. Teresi* (1962), Milwaukee

Alternate to SMS—*Dr. Lars Kleppe* (1962), Beloit

ASCP Councilor—Dr. Robert S. Haukohl (1960–1962), Milwaukee

CAP Assemblymen—*Dr. Norbert Enzer* (1962), Milwaukee; Dr. Frank Glassy (1963), Marshfield

Board of Censors—*Dr. Robert Fink* (1960–1962), Eau Claire; *Dr. Philip G. Piper* (1961–1963), Madison; *Dr. Edward A. Brucker, Jr.* (1961–1964), Madison

Madison Chapter, American Academy of GP

Dr. James Moore, Madison, was elected president-elect of the Madison Chapter of the American Academy of General Practice at a meeting at Nob Hill in October. *Dr. Russell Owen*, Madison, was elected secretary and *Dr. Lloyd Kellogg*, Oregon, was elected treasurer.

Wisconsin Society of Obstetrics and Gynecology

A scientific program by the Wisconsin Society of Obstetrics and Gynecology was held October 21 at Bardeen Auditorium on the University of Wisconsin campus, Madison. President of the Society, *Dr. A. A. Cantwell*, Shawano, gave the introductory remarks to open the all-day session.

Papers presented were: "Abdominal Pregnancy" by Dr. Joseph Kopcha of Gary, Ind.; "Uretero Pelvic Spatial Relationships" by *Dr. F. J. Hofmeister*, associate clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee; "Chromosomal Abnormalities in the Human" by Dr. David W. Smith, assistant professor of pediatrics, University of Wisconsin Medical School, Madison; "Experiences with the Incompetent Cervix" by *Dr. Herbert Sandmire*, Green Bay; "The Use and Abuse of Radical Pelvic Surgery" by Dr. Richard Mattingly, professor and chairman of the Department of Obstetrics and Gynecology, Marquette University School of Medicine, Milwaukee; and "Cancer of the Vulva with Emphasis on Epithelial Tumors" by Dr. John R. G. Gosling, Ann Arbor, Mich.

A panel discussion on "Bleeding Problems in Gynecology and Obstetrics" was moderated by *Dr. Ben Peckham*, professor and chairman of the Department of Obstetrics and Gynecology, UW Medical School, Madison. Panel members were Drs. Mattingly, Gosling, and *Dallas V. Clatanoff*, assistant professor of medicine, UW Medical School, Madison. Cases were presented by *Dr. William Kiekhofer*, assistant professor of obstetrics and gynecology, UW Medical School.

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features the following recent books in their full page advertisement appearing elsewhere in this issue:

GRAHAM, SOTTO AND PALOUCEK—CANCER OF THE CERVIX—full and authoritative coverage of the diagnosis and management of cervical cancer—from Roswell Park Memorial Institute.

HOGAN AND ZIMMERMAN—OPHTHALMIC PATHOLOGY—an atlas and textbook on diagnosis of diseases of the eye and on the pathology of involved tissue.

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NEWS OF WISCONSIN PHYSICIANS

Dr. Robin Allin Joins Dean Clinic

Dr. Robin Allin, a specialist in internal medicine, in October joined the staff of the Dean Clinic in Madison. He is a 1934 graduate of the University of Wisconsin Medical School. He served a three-year residency in internal medicine at the University Hospitals. A diplomate of the American Board of Internal Medicine, Doctor Allin has been engaged in private practice in Madison since his return from military service in 1946.

Doctor Wagener to Salem Clinic

Dr. Nicholas R. Wagener in September became associated with the Salem Clinic. He is a 1957 graduate of the University of Wisconsin Medical School. A native of Sturgeon Bay, Doctor Wagener is the grandson of Dr. N. Z. Wagener of Sturgeon Bay.

Doctor Leonhardt Joins Alma Clinic

Dr. Johannes L. Leonhardt joined the staff of the Community Clinic at Wabasha in September. He had been a fellow in general surgery at the Mayo Clinic, Rochester, Minn. A native of Germany, Doctor Leonhardt graduated from the University of Erlangen Medical School in Erlangen, Germany, in July 1951.

Re-elected to Whitehall Hospital Board

Drs. R. L. MacCornack, Sr., and *N. S. Simons*, Whitehall, were re-elected to the Board of Directors of the Whitehall Community Hospital at the annual meeting held early in September.

Takes Over Doctor Welbourne Practice

Dr. William H. Reed, a surgeon from Skokie, Ill., took over the practice of the late Dr. R. P. Welbourne at Watertown in September. Doctor Reed is a native of Albuquerque, N. M. He is a 1954 graduate of the medical school of Northwestern College, Evanston, Ill. He interned for one year at Cook County Hospital and for the past four years has been a resident in surgery at the hospital.

Dr. M. W. Stuessy Shows Film

Dr. M. W. Stuessy, Brodhead, showed a cancer film at a public program sponsored by the Brodhead Civics Club in conjunction with the local unit of the American Cancer Society, Wisconsin Division, on September 11. All women in the area were urged to attend and learn more about the "Pap" smear test for uterine cancer. Doctor Stuessy is a member of the State Medical Society's Committee on Cancer.

Physicians whose names appear in italic are members of the State Medical Society.

Opens Practice with Doctor Haines

Dr. Darrell A. Jaques in September opened a medical practice as a general physician and surgeon in Green Bay, in partnership with *Dr. A. W. Haines*. Doctor Jaques received his medical degree from the University of Michigan after which he entered military service.

Doctor Ochsner To Fort Snelling

Dr. C. G. Ochsner, who has been a physician and surgeon for the past 28 years at Wabasha, accepted a new position with the Veterans Administration at Fort Snelling, Minn., in September.

Psychiatrist Speaks to Mothers' Group

Dr. Kathryn Bemmann, psychiatrist at the Milwaukee Sanitarium, spoke on "Adventures of the Mind" at a meeting of the YWCA in October. Her talk was part of an all-day program conducted by the YWCA for mothers between the ages of 18 and 45.

New Physician for Platteville

Dr. Milton Stuessy, who for the past two years has been associated with *Drs. E. D. Sorenson* and *J. A. Rawlins* in Elkhorn, will begin medical practice in Platteville about January 1. He is a 1954 graduate of the University of Wisconsin Medical School. Following internship at Memorial Hospital, South Bend, Ind., Doctor Stuessy was associated with *Dr. Stanley Marshall* at Hollandale for a short period before entering the army medical corps. After his release from service, he was associated with *Drs. D. P. Cupery* and J. Davis in a clinic at Markesan.

Waterloo Physician to New York

After six years as a general practitioner in Waterloo, *Dr. J. Ralph Fowler* accepted a position as associate medical director of J. B. Roerig and Co., a pharmaceutical sales division of Charles Pfizer and Company, Inc. Doctor Fowler moved to New York City in September.

Opens Office in Eau Claire

Dr. William M. Walter, a native of Eau Claire, opened an office in that city in October. His practice will be centered mainly in general surgery. He is a 1955 graduate of the St. Louis University School of Medicine, St. Louis, Mo. He served a one-year internship at Madison General Hospital and also spent a three-year residency in general surgery at the same hospital.

Dr. Patricia Lanier Speaker

Dr. Patricia Lanier, Kewaunee, was guest speaker at a rehabilitation session held October 4 at the Army Reserve Center in Kewaunee. She discussed the medical aspects of diabetes.

Attends Pediatrician Meeting in Chicago

Dr. Leo F. Timp of the Hudson Clinic staff attended the meeting of the American Academy of Pediatrics held the first of October in Chicago.

Doctor Richtsmeier Speaks to Kiwanians

"Facts, Fads and Fats" was the subject of a talk by *Dr. A. J. Richtsmeier* of Madison at a meeting of the Baraboo Kiwanis Club in late September.

Attend Surgery Meeting

Six Milwaukee area surgeons attended the 47th annual meeting and clinical congress of the American College of Surgeons held the first week in October in Chicago. They are: Drs. Larry C. Carey, Joseph C. Darin, *Edwin H. Ellison, John D. Hurley, Derward Lepley, Jr.*, and *Wilson Weisel.*

New Bloomer Hospital Medical Staff

Four physicians have been named to the medical staff of the newly opened Bloomer Community Memorial Hospital. They are: *Drs. D. F. Hudek, C. T. Clauson, M. W. Asplund* and *P. W. Murphy.*

Open Office at Fountain City

Dr. Thomas Chisholm and *Dr. A. S. Daniells*, associated with the new clinic at Arcadia, opened an office in October in Fountain City in the former *Doctor Skemp* quarters. Doctor Chisholm spends Tuesday afternoons at the office while Doctor Daniells spends Thursday afternoons there.

Dedicate New Clinic Building at Arcadia

More than 400 persons were present September 10 for the dedication of the recently completed clinic building which was completely financed through local contributions and pledges. Physicians practicing in the Arcadia area are *Drs. Elizabeth Comstock*, Thomas Chisholm and *Albert Daniells.*

Named Medical Director of Hoan Center

A 34-year-old specialist in internal medicine was appointed medical director of the Hoan Medical Center, Milwaukee, in September. He is *Dr. Elvin M. Bremer* who lives in Bayside and practices in Milwaukee. The Hoan Medical Center is the former Capitol Hospital. The executive committee of the Center is headed by John C. Zinos, executive director of district council 48 of the American Federation of State, County and Municipal Employes. Doctor Bremer accepted the position with the understanding that medical care would be offered by the hospital to the public generally and not just to union members. He has been selecting a medical staff for the Center.

Doctor Bremer is a native of Milwaukee. He is a 1951 graduate of the University of Wisconsin Medical School. After internship at the University of Indiana Medical Center, he returned to Madison for residency training in internal medicine at Wisconsin General Hospital. Doctor Bremer is a clinical instructor of medicine at Marquette University School of Medicine.

New Physician Serves Palmyra Area

Dr. R. C. Dougan, who practices in Beloit, is also serving the residents of Palmyra in the offices of *Dr. R. G. Handeyside* who is taking postgraduate work in Milwaukee.

Doctor Bartos Speaker at YWCA Meeting

Dr. Joseph Bartos, Waukesha, was guest speaker at a health education meeting sponsored by the recreation department of the local YWCA, on September 20. His subject was "Varicose Veins and Your Heart."

Marshfield Physician on Chicago Program

A paper on "Maple Bark Disease" or "Pneumonitis Due to Coniosporium Corticale" was presented by *Dr. D. A. Emanuel*, member of the department of internal medicine at the Marshfield Clinic, at the midwest regional meeting of the American College of Physicians in Chicago September 16. Co-author of the paper was F. J. Wenzel, director of the laboratories of the Marshfield Clinic.

Doctor Emanuel's studies of this disease are being aided by the Marshfield Clinic Foundation for Medical Research under a grant from the National Institutes of Health for study of lung diseases.

Algoma Physician Lectures on Heart Disease

Dr. J. F. March of Algoma was a speaker at the annual county teachers' institute held in Kewaunee in September. He discussed "Health Research in Control of Heart Disease."

Dr. Bert Milson in Green Bay Office

Dr. Bert Milson began a practice in general surgery at Beacon Medical Center, Green Bay, in September. He is associated with his father, *Dr. Louis Milson*, and *Dr. Donel Sullivan.* Doctor Milson just completed a four-year residency in general surgery at Milwaukee County Hospital. He received his medical degree in 1956 from Marquette University School of Medicine.

OBITUARIES

Dr. Maurice B. Byrnes, Milwaukee, a general practitioner with a special interest in surgery, died September 14, 1961, at the age of 61.

A native of Iowa, Doctor Byrnes was a 1924 graduate of Marquette University School of Medicine. He interned at Milwaukee County General Hospital and completed his residency there in 1926, at which time he established his practice in Milwaukee. He was chief of staff of Misericordia Hospital, Milwaukee, from 1957 to 1959.

Medical affiliations include The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, and the American Academy of General Practice. He was a past president of the Catholic Physicians Guild in Milwaukee.

Surviving are his widow, Mary; five sons and three daughters.

Dr. James E. Newton, physician in Hudson for more than 40 years, died September 19, 1961, at the age of 75.

Born at Detroit Lakes, Minnesota in 1886, Doctor Newton received his medical degree from Loyola University Medical School, Chicago, in 1913. The following year he practiced in Athens, Tennessee, coming to Windsor, Wisconsin, in 1915. He later moved to Hudson, where he was in private practice until the time of his death.

A member of the Pierce–St. Croix County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association, Doctor Newton was also active in the American Heart Association and the American Association of Railway Surgeons. He was mayor of his community for 16 years.

Surviving are his widow, Lottie, a son and a daughter.

Dr. Charles Malone, Jr., Madison died September 24, 1961, at the age of 45.

Born in Boston, Mass., in 1916, Doctor Malone was a 1942 graduate of Tufts Medical School in Boston. Following internship at St. Clare's Hospital, New York City, he completed residency training in anesthesiology at University Hospital, Columbus, Ohio, and Mt. Auburn Hospital, Cambridge, Mass.

Doctor Malone served in World War II, and also in the Korean conflict. Upon his return he established practice in Westfield, Wisconsin, and later practiced in Plainfield, Hancock, Independence and Stanley.

Dr. Joseph A. Baer, who received his residency training in psychiatry at the University of Wisconsin Hospitals, died October 13, 1961, at Newhall, California, at the age of 31.

A native of Milwaukee, Doctor Baer was a 1956 graduate of the University of Wisconsin Medical School. After internship at the University of Oregon, he returned to Wisconsin for his residency.

He is survived by his mother, Mrs. J. A. Baer of Milwaukee.

Dr. Walter A. Schweitzer, Milwaukee general practitioner, died October 13, 1961, at the age of 64.

A native of Milwaukee, Doctor Schweitzer was a 1929 graduate of Marquette University School of Medicine. Following internship at Milwaukee County Hospital, he established his practice in that city. In addition to his general practice, he had a special interest in industrial medicine.

Doctor Schweitzer was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association.

He is survived by his widow, Alice, and two children.

Dr. Charles J. Maercklein, Redgranite general practitioner, died October 14, 1961, at the age of 85.

Born in Newberg, Wisconsin, he was a 1902 graduate of the Wisconsin College of Physicians and Surgeons in Milwaukee. He practiced in Sheboygan and Redgranite.

Surviving are his widow, Louise; one daughter, Mrs. Ole Sinses, Cornell; two sons, Richard and Charles E., both of Sheboygan; and a brother, Dr. Otto C. Maercklein, of Mott, North Dakota.

Dr. Irving I. Cowan, Milwaukee, a specialist in radiology, died October 17, 1961, at the age of 54.

A native of Pennsylvania, Doctor Cowan was a 1931 graduate of Vanderbilt University Medical School. He interned at McKeesport, Pa., City Hospital and received his residency training at Mt. Sinai Hospital in New York City. With the exception of military service during World War II, he practiced in Milwaukee until the time of his death.

Doctor Cowan was a member of The Medical Society of Milwaukee County, serving on its Research Committee; and a member of the State Medical Society of Wisconsin and the American Medical Association. He was also a Diplomate of the American Board of Radiology, Fellow of the American College of Radiology, member of the Radiological Society of North America, past president of the Wisconsin State Radiological Society, past president of the Milwaukee Roentgen Ray Society, and member of the Milwaukee Academy of Medicine. He served as assistant clinical professor of radiology and was founder and director of the first department of isotopes in Milwaukee at the Marquette University School of Medicine.

Surviving are his widow, Joan; three sons, Mark, Jon and David; and one daughter, Claudia.

OBITUARIES *Continued*

Dr. Ernest L. Bolton, Appleton surgeon, died October 17, 1961, at the age of 84.

A native of Tomah, Wisconsin, Doctor Bolton was a 1903 graduate of the Marquette University School of Medicine. Following internship at St. Joseph's Hospital, Milwaukee, he established his practice in Chilton, leaving in 1918 for service in World War I. Returning from service, he established practice in Appleton in 1920 and remained active until about four years ago when he retired. He was president of the medical staff of St. Elizabeth Hospital in 1937.

Doctor Bolton is a past president of both the Outagamie and Calumet County Medical Societies, a life member of the State Medical Society of Wisconsin, and a member of the American Medical Association. He was honored by his county society in 1953 for 50 years of service to his community.

Surviving are his widow, Mary Maude, and two sons, Glenroy G. of St. Paul and Wayne C. at home.

Dr. Charles C. Differt, retired Milwaukee physician, died October 19, 1961, at the age of 81 in Sheboygan.

Born in Milwaukee, Doctor Differt was a 1903 graduate of Marquette University School of Medicine. He practiced in Milwaukee from 1903 to 1950 when he retired due to illness. He lived in Sheboygan for the past 12 years.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association.

Surviving are his widow, Inez; a son, Aubrey of Sheboygan; and a daughter, Mrs. Shirley Schaefer, also of Sheboygan.

Dr. Philip G. Frey, retired Milwaukee general practitioner, died October 25, 1961, at the age of 79.

Born in Hartford, Wisconsin, Doctor Frey was a 1907 graduate of Northwestern University Medical School. He received his pre-medical education at the University of Wisconsin. He completed his internship at Alexian Brothers Hospital, Elizabeth, New Jersey, and established his practice in Spooner in 1908. In 1913 he moved to Washburn and five years later moved to Milwaukee where he practiced until his retirement in 1953. He was the fifth doctor to be honored by Deaconess Hospital by being elected to its honorary staff.

Doctor Frey was a member of The Medical Society of Milwaukee County, a life member of the State Medical Society of Wisconsin, and a 50-year member of the American Medical Association.

Surviving are a daughter, Kathleen A., and two sons, Philip T. and Louis C. Frey.

Dr. Elmer A. Schmidt, Elm Grove, a general practitioner, died October 28, 1961, at the age of 56.

Born in Milwaukee, Doctor Schmidt was a 1935 graduate of Marquette University School of Medicine. After internship at St. Mary's Hospital, Milwaukee, he practiced in South Milwaukee and Wauwatosa before establishing his practice in Tomah. In 1943, he moved to Waupun where he practiced until 1952, when he located in Elm Grove.

Doctor Schmidt was a member of the Waukesha County Medical Society, State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow, Mae; and a daughter, Judy Ann.

Dr. Bertha Reynolds, Avoca, a general practitioner for many years in Lone Rock, died October 31, 1961, at the age of 93.

Doctor Reynolds was born in 1868 in Thiensville, Wisconsin. She was a 1901 graduate of Lincoln Medical College, Lincoln, Nebraska. Doctor Reynolds first practiced in Prairie du Chien, moving to Lone Rock in 1903 where she remained until her retirement in 1940. Moving to Avoca at that time, she soon returned to active practice when that community lost its only physician, retiring again in 1951. She was honored by the University of Wisconsin in 1939 for her outstanding service to agriculture and rural living. In 1952 she became a member of the State Medical Society's Fifty-Year Club.

Doctor Reynolds was an honorary member of the Iowa County Medical Society and the State Medical Society of Wisconsin.

Dr. George S. King, Hudson, died November 1, 1961, in St. Paul, Minnesota, at the age of 66.

Born in Chippewa Falls, Wisconsin, he was a 1925 graduate of the University of Minnesota Medical School. He practiced for 25 years in St. Paul. Upon retirement in 1950, he moved to Hudson, where he has lived since that time.

Surviving are his widow, Evelyn, and one son, Robert.

Dr. Edward S. Elliott, physician at Fox Lake for 53 years, died November 4, 1961, at the age of 84.

Born in Sussex, Wisconsin, he was a 1905 graduate of the Marquette University School of Medicine. He practiced in northern Wisconsin for two years before establishing his practice in Fox Lake. In 1958 he was honored by his community for 50 years of service. He was city health officer at Fox Lake for many years.

Doctor Elliott was a past president of the Dodge County Medical Society, life member of the State Medical Society of Wisconsin, and a member of the American Medical Association.

Surviving is his widow.

Dr. Edward D. Schwade, Milwaukee psychiatrist, died November 4, 1961, at the age of 56.

A native of Chicago, Illinois, Doctor Schwade was a 1930 graduate of Marquette University School of Medicine. Following internship and residency at Milwaukee County General Hospital, he established his private practice in Milwaukee. During World War II, he served as chief of neuropsychiatric service and chief of the medical services at Camp Fannin, Texas.

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Doctor Schwade was a member of The Medical Society of Milwaukee County, and served as chairman of the society's Mental Hygiene Division. He was chairman of the State Medical Society of Wisconsin's Division on Nervous and Mental Diseases, and was a member of the American Medical Association. He was also a member of the Milwaukee Neuropsychiatric Society, and the American Psychiatric Association, the American and Central Electroencephalographers Associations, and the International Congress on Neurology and Physiology. He was neuropsychiatric consultant to the State Rehabilitation Division, Cerebral Palsy Clinic of Milwaukee, and Milwaukee Police Department, and a member of the faculty at Marquette University School of Medicine.

E. D. SCHWADE, M.D.

Doctor Schwade served as director of the Research Clinic in Convulsive Disorders at Milwaukee County General Hospital, was a member of the board ofdirectors of the Wisconsin Epilesy League, and of the Milwaukee County Society of Mental Health. He was a one time a member of the Milwaukee Com-Rights, and worked with the Governor's Committee for the Emment of the Physically Handicapped. Doctor Schwade played an active part in revision of Wisconsin laws governing epileptics.

He is survived by his widow, Nancy, and a son, Franklin P. Schwade, Milwaukee.

Dr. Fabian J. Gosin, a founder of the Gosin Clinic in Green Bay, died November 6, 1961, in Long Beach, California.

Born in Walhain, Wisconsin, he was a 1916 graduate of the Marquette University School of Medicine. Following service in France in World War I, he established his practice in Green Bay. In 1929, he organized the Gosin Clinic in that city with his brother, Dr. Donne F. Gosin, and remained in active practice until moving to California in 1959.

He was a member of the Brown County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Surviving are his widow, Gladys, and one son, Dr. Robert F. Gosin, Long Beach, California.

Dr. Raymond R. Rivard, Shawano, a specialist in ophthalmology, died November 13, 1961, at the age of 63.

Born in Fairchild, Wisconsin, he was a 1925 graduate of Marquette University School of Medicine. After internship at Milwaukee County Hospital, he entered private practice at Little Chute, later moving to Two Rivers. In 1937 he moved to Shawano and in addition to his private practice there was physician for the Menominee Indian Reservation. In 1944 Doctor Rivard began residency training in his specialty at Illinois Research and Educational Hospital. Upon completion he spent one year at the Nelson Clinic in Manhattan, Kansas, returning to Shawano in 1947. In 1956 he again became physician for the Menominee reservation. He was retired at the time of his death.

Doctor Rivard was a past president of the Shawano County Medical Society and a member of the State Medical Society of Wisconsin and the American Medical Association.

Surviving is his widow, Edna.

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SOCIETY RECORDS

Membership Report as of August 31, 1961

NEW MEMBERS

Laszlo Leslie Fai, 1202 60th Street, Kenosha.
Werner A. Hauschild, Sixth Avenue at 60th Street, Kenosha.
Barbara A. Brew, 30 South Henry Street, Madison.

CHANGES OF ADDRESS

F. C. Kinsman, 1117 Agnes Street, Eau Claire.
R. H. Brodhead, P. O. Box 838, Wausau.
C. R. Jackson, 1023 Regent Street, Madison.
F. L. DeGroat, Jr., 5721 North Bay Ridge, Milwaukee.
Jack Silberman, 7450 North Navajo Road, Fox Point 17.
Jack E. Geist, 2590 North Stowell, Milwaukee.
Brian C. McLaughlin, 2266 North Prospect Avenue, Milwaukee.
Edward C. Schmidt, 2266 North Prospect Avenue, Milwaukee.
Henry B. Wengelewski, 5232 West Oklahoma Avenue, Milwaukee.
J. D. Spankus, 4922 North Cumberland Boulevard, Milwaukee 11.
F. M. Schammel, 811 Grant Street, Stoughton.
F. H. Zimmerman, 212½ East Main Street, Watertown.
R. J. Bothum, 1313 Fish Hatchery Road, Madison.
Charles T. Atkinson, 1134 West North Avenue, Milwaukee.
John J. Czajka, 8511 West Lincoln Avenue, Milwaukee.
B. A. Lungmus, 4201 North Prospect Avenue, Milwaukee.
Louis T. Maxey, 720 North Jefferson Street, Milwaukee.
Thomas F. McCormick, 2266 North Prospect Avenue, Milwaukee.
John T. Schmitz, 2266 North Prospect Avenue, Milwaukee.
Lillian M. Thomas, 5232 West Oklahoma Avenue, Milwaukee.
George S. Woodward, 7635 West Blue Mound Road, Milwaukee.
Arno R. Langjahr, 9086 North Meadowlark Lane, Milwaukee.
Michael A. Polacek, 3235 South 80th Street, Milwaukee.
Arthur A. Rand, 3942 North 54th Street, Milwaukee.
Abraham B. Schwartz, 2921 East Newport Avenue, Milwaukee.
Farrell Golden, 1313 Fish Hatchery Road, Madison.
Melvin M. Askot, 8025 North 63rd Street, Milwaukee.
William Atkinson, 11932 West Arthur Street, Milwaukee.
Doralea R. Harmon, P. O. Box 2067, Madison.
William H. Drischler, 7200 North Lake Drive, Milwaukee.
Volney B. Hyslop, 620 North Brookfield Road, Brookfield.
Gerald R. Zupnik, 8689 North Seneca Road, Milwaukee.
Joseph C. Fralich, 810 Main Street, Racine.
C. J. Schroth, 808 Third Street, Wausau.
Donald A. Smith, 104 South Main Street, Room 320, Fond du Lac.
Roman Bilak, 6032 40th Avenue, Kenosha.
Neil R. Thomson, 409 East Silver Spring Drive, Milwaukee.
Thomas M. Shearer, Columbus, to 2 Canal Street, Edgerton.
Dale M. Everson, Platteville, to P. O. Box 42, Shell Rock, Iowa.
Miles B. Smith, Wood, to 2266 North Prospect Avenue, Milwaukee.
Christopher A. Graf, Marshfield, to 2217 South Memorial Place, Sheboygan.
John R. Haselow, Fremont, to 201 East Wisconsin Avenue, Neenah.
Donald E. Chisholm, Silver Springs, Colorado, to 600 65th Street, Kenosha.
Boyd F. Nirschl, Milwaukee, to 3372 Georgetown Place, Santa Clara, California.
Freddie N. Peterson, Milwaukee, to 234 Cochituate Road, Wayland, Massachusetts.
James T. Schulz, Milwaukee, to 649 B Avenue, Coronado, California.
W. R. Schwartz, Milwaukee, to 8733 Glencoe Circle, Wauwatosa 13.
Paul H. Biever, Port Washington, to 208 East Wisconsin Avenue, Milwaukee.
Donald Burke, Milwaukee, to 1904 Neptune Avenue, Racine.
Edwin O. Sheldon, Madison, to 7217A–MC, Fort Carson, Colorado.
Jordon Frank, Ohio, to 4914 Knox Lane, Madison 5.
Charles B. Larkin, Madison, to 1510 Orchid Drive, San Bernardino, California.
Marvin G. Jumes, Madison, to 714 North 9th Street, Sheboygan.
Raymond F. Doyle, Watertown, to Veteran's Administration Center, Wood.
Addie M. Schwittay, Jamaica, to 5217 Tonyawatha Trail, Madison.
Glen A. Childers, Brookfield, to 6917 Altamiro Street, Coral Gables, Florida.
Salvatora Fricano, Milwaukee, to Veteran's Administration Hospital, Wood.
Eugene J. Ackerman, Cudahy, to 111 West Indian Creek Court, Milwaukee.
H. D. Baernstein, Racine, to Linda University, 1204 North State Street, Los Angeles 33, California.
Thomas E. Bachhuber, Madison, to 637 S. E. 112th Street, Portland 16, Oregon.

William Walter, Madison, to 1815 Badger Avenue, Eau Claire.
C. Sargent, Baileys Harbor, to 1825 New York Avenue, Manitowoc.

Membership Report as of September 30, 1961

NEW MEMBERS

William T. Brodhead, 1313 Fish Hatchery Road, Madison.
S. L. Inhorn, 1300 University Avenue, Madison.
Judith D. Walton, 807 Dellwood Circle, Madison.
James D. Collins, 913 Magnolia Lane, Madison.
Paul L. Davidson, 2 West Gorham Street, Madison.
Mitchell A. Rapkin, 1129 Catalpa Circle, Madison.
Heinz Vogel, 301 Troy Drive, Madison 4.
John D. Maloney, 424 Seymour Drive, Valdosta, Georgia.
Josef Enzinger, Park Falls.
Otto K. Stewart, 1226 North 8th Street, Sheboygan.
Herman J. Dick, Sheboygan Memorial Hospital, Sheboygan.

CHANGES OF ADDRESS

William Walter, 131 South Barstow Street, Eau Claire.
Nat Goldberg, 3531 West Burleigh Street, Milwaukee 10.
T. E. Kilkenny, 419 Roosevelt Avenue, Eau Claire.
W. T. Atkinson, Jr., 10247 West National Avenue, Milwaukee.
Amrum Lakritz, 625 North Milwaukee Street, Milwaukee.
Louis A. Bernhard, 1610 North Prospect Avenue, Apt. 105, Milwaukee.
Morris Kretchmar, 2202 West Silver Spring Road, Milwaukee.
W. G. Long, 10247 West National Avenue, Milwaukee.
Archie H. Tax, 6001 West Center Street, Milwaukee.
L. J. Ganser, 1 West Wilson Street, Room 344, Madison 2.
Edward J. Schelble, 2266 North Prospect Avenue, Milwaukee.
Robert L. Temple, Wood, to 7419 West Warnimont Avenue, Milwaukee.
C. C. Knight, California, to 1300 University Avenue, Madison 6.
Rudolph J. Scrimenti, Milwaukee, to 4713 Chester Avenue, Philadelphia 43, Pennsylvania.
Albert W. Bryan, Madison, to Veterans Administration Hospital, Tomah.
Jack D. Edson, Madison, to 778 South Fairlawn Way, Waukesha.
Paul R. Glunz, Milwaukee, to 915 North Central Avenue, Marshfield.
Thomas B. Puls, Florida, to 3431 South 38th Street, Milwaukee.
Robert A. Turcott, Lake Mills, to 1818 Ivywood Drive, Ann Arbor, Michigan.
W. W. Stebbins, Madison, to 222—8th Avenue North, St. Petersburg, Florida.
Douglas A. Gutheil, Whitelaw, to Hickory Grove Sanitorium, West De Pere.
R. L. Wiesen, Wood, to 4981 West Blue Mound Road, Milwaukee.
R. G. Evenson, Footville, to Veterans Administration Hospital, Wood.
R. W. Wilhoite, Milwaukee, to 418 Church Street, Evanston, Illinois.
James J. Nora, Cambridge, to Beloit Clinic, Beloit.
F. A. Kordecki, Winnebago, to 808—5th Street Northwest, Independence, Iowa.
John T. Hagenbucher, Madison, to 5808 Cleves Lane, Washington 16, D. C.
R. C. Wolfgram, Milwaukee, to Route 4, Box 746, Oshkosh.
Theodore S. Roberts, Madison, to Veterans Administration Hospital, Salt Lake City, Utah.
H. A. Devine, Jr., Fond du Lac, to 9311 Fermiane, San Diego, California.
Leonard O. Langer, Madison, to 2708 Matilda Street, St. Paul 17, Minnesota.
G. T. Mohler, Oconto, to Surgeon 1st Battle Group, 32nd Infantry Division, Ft. Lewis, Washington.

Membership Report as of October 31, 1961

NEW MEMBERS

Gerald P. Fitzgerald, 709 North Ringold Street, Janesville.
Kenneth H. Rusch, 1 West Wilson Street, Room 344, Madison 2.
John B. Wear, Jr., 1215 Wellesley Road, Madison 5.
Robert L. Bolton, 10247 West National, Milwaukee.
Paul L. Trump, Jr., 15 Craig Avenue, Madison.
Frank Winston, 2700 Marshall Court, Madison 5,
Elwood W. Kreutzer, 2216 Wood Road, Middleton.
Sonja D. Monson, 301 Troy Drive, Madison.
Robert E. Whiteway, 1836 South Avenue, La Crosse.
Thomas R. Hansen, 917 North Osborne Avenue, Janesville.
Wesley E. McNeal, 720 Marquette Avenue, Green Bay.

CHANGES OF ADDRESS

George C. Bares, 6001 West Center Street, Milwaukee.
Carl G. Dunst, 2266 North Prospect Avenue, Milwaukee.
Bernard A. Hoermann, 918 South 24th Street, Milwaukee.
Benjamin J. Malnekoff, 836 North 12th Street, Milwaukee.
Edward L. Martineau, 2929 North Oakland Avenue, Milwaukee.
Abe Sosman, 836 North 12th Street, Milwaukee.
Ross R. Weller, 836 North 12th Street, Milwaukee.

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Louis J. Kurten, 2405 Northwestern Avenue, Racine.

Peter A. Gardetto, 2405 Northwestern Avenue, Racine.

William C. Harris, 2405 Northwestern Avenue, Racine.

William J. Madden, 2405 Northwestern Avenue, Racine.

Carl R. Newman, 2405 Northwestern Avenue, Racine.

Henry E. DeGroat, 2405 Northwestern Avenue, Racine.

A. J. Schleper, 312 Seventh Street, Racine.

Norman C. Erdmann, 601 North 8th Street, Manitowoc.

Nathan S. Davis, Jr., 601 North 8th Street, Manitowoc.

M. C. F. Lindert, 6745 West Wells Street, Milwaukee 13.

Robert D. O'Connor, 6745 West Wells Street, Milwaukee 13.

M. J. Ciccantelli, 6745 West Wells Street, Milwaukee 13.

Bruno J. Peters, 6745 West Wells Street, Milwaukee 13.

Julius M. Meyer, 6745 West Wells Street, Milwaukee 13.

Armin R. Baier, 6745 West Wells Street, Milwaukee 13.

Walter H. Thiede, 6745 West Wells Street, Milwaukee 13.

T. J. Pfeffer, 6745 West Wells Street, Milwaukee 13.

John A. Cox, 2682 North 27th Street, Milwaukee 10.

D. B. Smith, 4414 Regent Street, Madison.

Sara G. Geiger, 1961 North Summit Avenue, Milwaukee 2.

R. M. Lotz, 605 Walker Avenue, Eau Claire.

Roger L. Hepperla, 4200 North 89th Street, Milwaukee 22.

Michael J. Watunya, 600 Exchange Building, La Crosse.

Howard L. Correll, 6745 West Wells Street, Milwaukee 13.

Donald P. Davis, Illinois, to 212 Wickham Avenue, Beckley, West Virginia.

T. W. Klein, Milton Junction, to Box 555, Marathon, Florida.

Marvin J. Roesler, Janesville, to Box 422, Route 2 Delavan.

Doralea R. Harmon, Madison, to 1102 East 51st Street, Savannah, Georgia.

Dean P. Epperson, Watertown, to 155 East Wisconsin Avenue, Oconomowoc.

J. R. Nellen, California, to 5622 West Jackson Park Drive, Milwaukee 19.

Michael D. Ballard, Milwaukee, to 6620 Roosevelt Boulevard, Philadelphia, Pennsylvania.

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RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by written examination by the State Board of Medical Examiners at a meeting in Madison:

August 8, 1961	*School of Graduation*	*Year*	*City*
Dick, C. A. W.	Marquette University	1960	Milwaukee
Meyer, T. C.	Witwatersrand University, South Africa	1950	Madison
Walter, J. D.	Marquette University	1960	Milwaukee
August 11, 1961			
Asinas, I. L.	University of Santo Tomas, Philippines	1955	Milwaukee
Baylon, V. A.	Manila Central University, Philippines	1955	Milwaukee
Braun, N. P.	Welsh National School, South Africa	1953	Monroe
Chisholm, T. P.	Marquette University	1959	Arcadia
Crennell, E. H.	University of Dublin, Ireland	1955	Madison
Fels, H. J	University of Heidelberg, Germany	1957	Milwaukee
Hoffman, G. C.	University of Cambridge, England	1950	Cleveland, Ohio
August 21, 1961			
Anderson, J. A.	University of Wisconsin	1960	San Diego, Cal.
Baker, N. H.	University of Chicago	1960	Madison
Balistrieri, J. J.	Marquette University	1960	Milwaukee
Banaszak, E. F.	Marquette University	1960	Milwaukee
Barber, M. L.	Marquette University	1960	Mukwonago
Bein, R.	Northwestern University	1958	West Allis
Belsito, A. A.	Marquette University	1959	Virginia Beach, Va.
Borchardt, R. E.	University of Wisconsin	1960	Racine
Bracker, E. F.	Northwestern University	1960	Green Bay
Brown, J. F.	Marquette University	1960	Madison
Bukosky, R. J.	Marquette University	1960	Linden, N. J.
Cerletty, J. M.	Marquette University	1958	Milwaukee
Cloud, W. M.	Northwestern University	1959	Belvedere, Cal.
Cram, D. L.	University of Wisconsin	1959	Sacramento, Cal.
Dally, A. D.	Marquette University	1960	Madison
Dettmann, F. G.	Marquette University	1960	Milwaukee
Ecks, J. A.	Marquette University	1960	Wauwatosa
Edwards, R. W.	University of Wisconsin	1960	Richland Center
Flaherty, T. T.	Marquette University	1959	Amarillo, Tex.
Gagan, R. J.	Marquette University	1960	Janesville
Gallagher, E. J.	Marquette University	1960	Oakland, Cal.
Godersky, R. G.	Marquette University	1960	San Jose, Cal.
Goodnough, D. E.	University of Wisconsin	1959	Richards-Gebaur AFB, Mo.
Halloran, M. J.	Marquette University	1959	St. Louis, Mo.
Holmes, G. W.	University of Wisconsin	1954	Greendale
Isert, J. A.	Marquette University	1960	San Diego, Cal.
Keelan, M. H., Jr.	Marquette University	1960	Wauwatosa
Kegel, T. A.	Marquette University	1960	West Allis
Kind, A. C.	University of Wisconsin	1960	Madison
Kivlin, T. M.	University of Wisconsin	1960	Oshkosh
Korbitz, B. C.	University of Wisconsin	1960	Madison
Marnocha, J. R.	Marquette University	1960	Hayward, Cal.
McDermott, P. L.	Marquette University	1960	Milwaukee
McIntosh, D. E.	Marquette University	1960	Parsons, Kan.
McManus, J. T.	Marquette University	1960	Chicago, Ill.
Murray, F. E.	University of Wisconsin	1960	Milwaukee
Rogers, J. R.	Marquette University	1960	San Francisco, Cal.
Sacco, R. N.	University of Wisconsin	1960	Baltimore, Md.
Schneider, W. F.	Marquette University	1960	San Antonio, Tex.
Shampo, D. R.	University of Wisconsin	1960	Niagara
Whitcomb, N. J.	University of Wisconsin	1960	Milwaukee
Young, C. E.	University of Wisconsin	1960	Milwaukee
September 5, 1961			
Lee, J. E.	University of Wisconsin	1960	Waverly, Iowa
Prastka, G. J.	University of Wisconsin	1957	Ft. Carson, Colo.
September 11, 1961			
Shapiro, D.	Medical Institute of Tashkent, Russia	1944	Appleton
September 13, 1961			
Connaughton, J. P.	University of Dublin, Ireland	1956	Wauwatosa
September 29, 1961			
Martinez, R. M. E.	University of Santo Domingo, Dominican Republic	1953	Milwaukee

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GUEST SPEAKERS

E. M. Papper, M. D., New York, N. Y.
ANESTHESIOLOGY
Edward P. Cawley, M. D., Charlottesville, Va.
DERMATOLOGY
Julian M. Ruffin, M. D., Durham, N. C.
GASTROENTEROLOGY
Carroll L. Witten, M. D., Louisville, Ky.
GENERAL PRACTICE
Howard W. Jones, Jr., M. D., Baltimore, Md.
GYNECOLOGY
Thomas M. Durant, M. D., Philadelphia, Pa.
INTERNAL MEDICINE
Maxwell M. Wintrobe, M. D., Salt Lake City, Utah
INTERNAL MEDICINE
Bernard J. Alpers, M. D., Philadelphia, Pa.
NEUROLOGY
Ralph C. Benson, M. D., Portland, Ore.
OBSTETRICS
Victor A. Byrnes, M. D., St. Petersburg, Fla.
OPHTHALMOLOGY
John H. Moe, M. D., Minneapolis, Minn.
ORTHOPEDIC SURGERY
Albert C. Furstenberg, M. D., Ann Arbor, Mich.
OTOLARYNGOLOGY
Jeff Minckler, M. D., Denver, Colo.
PATHOLOGY
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(Optional extensions may be arranged)

For information concerning the Assembly meeting and the tour write Secretary, Room 105, 1430 Tulane Ave., New Orleans 12, La.

MEDICAL MEETINGS—POSTGRADUATE COURSES

1963 Surgical Meeting in Hawaii

The Ninth Congress of the Pan-Pacific Surgical Association will be held November 5–13, 1963, in Honolulu, Hawaii and the First Pan-Pacific Mobile Educational Lecture Seminar will be held November 13–December 10, 1963, in New Zealand, Australia, Thailand, the Philippines, Hong Kong and Japan.

The Ninth Congress offers an extensive scientific program of 300 leading surgeons in nine surgical specialties. The Seminar offers scientific meetings in each country presenting medical material unique to the areas.

For further information, write Dr. F. J. Pinkerton, Director General, Pan-Pacific Surgical Association, Suite 570, Alexander Young Building, Honolulu 13, Hawaii.

American College of Surgeons

Detroit will be host to the second of four 1962 Sectional Meetings of the American College of Surgeons. The scientific session will be held March 5 through 7, 1962, at the Sheraton–Cadillac hotel.

The program will include discussions on trauma in children, athletic injuries, fractures in the elderly, trauma of facial injuries, management of intractable pain, surgery of heart lesions in children, cancer of the head and neck, hiatal hernia, fistula in ano, surgery of the hand, stress incontinence in the female, surgery of endocrine disorders, justification for sphincter-saving operations for cancer of the rectum, indications for tracheostomy, and a symposium on surgical complications during pregnancy.

Dr. William H. Frackelton, Milwaukee, will be the moderator for a panel discussion on surgery of the hand Tuesday afternoon, March 6.

Other College Sectional meetings will be held in Memphis, March 26–28 and Washington, D. C., April 16–18.

UW Postgraduate Programs

Jan. 18–20, 1962: Problems and Perspectives in Medicine. Chairman—Dr. Ovid O. Meyer, chairman of the Department of Medicine. (Details in October issue)

April 5–7, 1962: Genetics in Pediatrics. Chairman —James F. Crow, Ph.D., professor of medical genetics, and Dr. Nathan J. Smith, chairman of the Department of Pediatrics. The physical and chemical basis of genetics will be presented with an analysis of pedigrees and the application of the Mendelian theory. Half-day sessions will be devoted to cytogenetics and congenital anomalies, inborn errors in metabolism, immunogenetics and genetic counseling. Blood protein genetics and tissue culture genetics will be discussed.

WISCONSIN CALENDAR COMING EVENTS

1962

Jan. 4: Half-day course in dermatology, UW, Wisconsin Center building, Madison.

Jan. 18–20: Postgraduate course on Problems and Perspectives in Medicine, Wisconsin Center building, Madison.

Jan. 31: Circuit teaching program, SMS, Vernon County Memorial Hospital, Viroqua.

Feb. 1: Circuit teaching program, SMS, Elks Club, Portage.

Feb. 1: Half-Day course in pediatrics, UW, University Hospital, Madison.

Feb. 21: Circuit teaching program, SMS, Village Inn, Delavan.

Feb. 22: Circuit teaching program, SMS, American Legion Club, Oconomowoc.

Mar. 8: Half-day course in orthopedics, UW, University Hospital, Madison.

Mar. 15: Annual meeting, Wisconsin Hospital Association, Hotel Schroeder, Milwaukee.

Apr. 5–7: UW postgraduate course, Genetics in Pediatrics, Drs. J. Crow and N. Smith, co-chrm., Wisconsin Center Building, Madison.

Apr. 12: Half-day course in gynecology—obstetrics, UW, University Hospital, Madison.

Apr. 26–28: UW postgraduate course, Psychosomatic Medicine, Dr. David Graham, chrm., Wisconsin Center Building, Madison.

May 3: Half-day course in therapeutics, UW, University Hospital, Madison.

May 8–10: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 10–11: UW postgraduate course, Orthopedic Surgery, Dr. H. Wirka, chrm., Wisconsin Center Building, Madison.

May 17–19: UW postgraduate course, Anatomy, Physiology and Pathology of the Holocrine, Apocrine and Eccrine Glands, Dr. S. Johnson, chrm., Wisconsin Center Building, Madison.

June 24–28: AMA Annual Meeting, Chicago, Illinois.

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California.

April 26–28, 1962: Psychophysiology in Medicine. Chairman—Dr. David T. Graham, associate professor of medicine. The course will present recent concepts and research developments in psychophysiology and psychosomatic medicine. There will be emphasis on scientific understanding of the emotional responses which lead to illnesses; on the social settings in which these responses arise; and on current attempts to define relations between psychological and psychodynamic variables on one hand, and physiologic and anatomic variables on the other.

May 17–19, 1962: The Eccrine, Aprocrine and Holocrine Glands of the Skin: Their Embryology, Anatomy, Distribution, Physiology, Function, Pathology and Biochemical Activity. Chairman—Dr. Sture A. M. Johnson, professor of dermatology and syphilology. Distinguished experimental and clinical investigators will present the anatomy, physiology and biochemical activity of these glands. The newer concepts of their functions with special reference to hormonal influences will be discussed. The newer concepts of specific disease processes, cystic fibrosis, sweat retention syndrome and others will be presented.

These programs will be held in the Wisconsin Center. General practitioners may receive Category I credits from the AAGP for participation in these programs. Advance reservations can be made by writing to: Coordinator of Postgraduate Program in Medical Education, 702 Langdon Street, Madison 6, Wisconsin.

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OB–GYN Meeting in Chicago

Leading physicians from throughout America have been selected as faculty for seven Correlated Seminars during next spring's Tenth Annual Clinical Meeting of The American College of Obstetricians and Gynecologists. It will be held in the Palmer House in Chicago on April 2–4, 1962. These seminars are designed to permit extra time for study in greater depth. They will be scheduled concurrently with the shorter Clinical Conferences.

Each Correlated Seminar will be divided into four one-hour sessions. The seven seminars cover the following topics: Toxemias of Pregnancy, Infertility, Neuropsychiatric Complications in Obstetrics and Gynecology, Radiation Therapy in Gynecologic Cancer, Reproductive Physiology, Heart Disease in Pregnancy, and Diagnosis and Management of Menstrual Disorders.

Advance registration for the meeting and for these Correlated Seminars will be open to Fellows of The ACOG in January. Other physicians also may register for a fee of $25.00. Further information may be obtained by writing Donald F. Richardson, Executive Director, at the College office, 79 West Monroe St., Chicago 3, Ill.

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Legal Limitations on Treating the Sick in Wisconsin

An Interpretation of The Medical Practice Act

HISTORICAL DEVELOPMENT

OVER ONE HUNDRED years ago the medical profession organized nationally for the principal purpose of elevating the standards of medical education and encouraging adequate licensing laws throughout the states.

In a period of less than 20 years before the organizational meeting of the American Medical Association in 1847 at Philadelphia, the number of medical schools in the United States had doubled. Most of these schools were commercial in nature, and their promoters sought to increase enrollment by reducing curriculum requirements and easing graduation and licensing requirements. Sixteen weeks was the accepted length of the college term. Some schools reduced this to thirteen weeks.[1]

The ratio of physicians to population was five times as great as in France, and it was felt that the over supply of doctors and inadequate medical education were "largely responsible for the rise of quackery and charlatanism."[2]

At least as early as 1835 efforts were made by responsible medical colleges and individual eastern state medical societies to upgrade medical education and—of equal importance—to divorce teaching from licensing.

It was soon recognized that these efforts, if they were to be effective, must be made through a concerted, organized national movement.

In 1845 the New York Medical Society adopted the following resolution:

> "WHEREAS, It is believed that a national convention would be conducive to the elevation of the standard of medical education in the United States; and
>
> "WHEREAS, There is no mode of accomplishing so desirable an object without concert of action on the part of the medical colleges, societies and institutions of all the states; therefore be it
>
> "*Resolved*, That the New York State Medical Society earnestly recommends a national convention of delegates from medical societies and colleges in the whole Union to convene in the city of New York on the first Tuesday in May in the year 1846 for the purpose of adopting some concerted action on the subject set forth in the foregoing preamble.
>
> "*Resolved*, That a committee of three be appointed to carry the foregoing resolution into effect."[3]

Morris Fishbein, M.D., states in his book, *A History of the American Medical Association*, p. 22, that this resolution "may be considered the first step toward the formation of the American Medical Association as we know it now."

Organizational problems, lack of cooperation by many medical colleges and public apathy impeded progress.

By 1893, however, fifteen states had enacted medical practice acts which required state examinations of all those who desired to practice medicine.[4] This was the breakthrough, and in a few years most states had adopted similar requirements.

The substantial improvement in the standards of medical education developed at a somewhat slower pace. It was not until 1907 that medical school inspection and rating by the Council on Medical Education gained public recognition and became truly effective. At that time there were 160 medical schools; 82 had been rated above 70, 46 between 50 and 70, and 32 below 50. Medical schools conducted solely for profit and night schools were condemned.[5]

It has, thus, been only during the past 50 years that the states have adopted effective Medical Practice Acts which restrict the unqualified and impose minimal requirements upon those seeking medical licensure. The same may be said of the voluntary efforts to elevate medical school requirements and standards.

Wisconsin presents a typical picture of Medical Practice Act development through the years. It is a story of legislative response to public demand for protection against the incompetent, the quack, the cultist and the charlatan.

The first halting legislative step seeking qualified practitioners appeared in Chapter 27, Revised Statutes of Wisconsin, 1849. It imposed the duty of examining medical students upon the censors of the county and state medical societies.

Successfully completing his examination, the student paid the president of the society $10 for a diploma and membership in the society. This dip-

loma and membership was little more than a badge of honor.

This regrettable state of statutory laxity continued until 1897 when the Wisconsin Legislature enacted our first real Medical Practice Act.[6] This act established the first state board of medical examiners of seven members appointed by the Governor. Three of the appointees were "regular physicians," two were "homeopathic physicians," and two were "eclectic physicians."

The homeopaths and eclectics in Wisconsin each had their own state societies which reflected a national pattern of developing cult practices. Dr. N. S. Davis, the first editor of the *Journal of The American Medical Society*, in a speech before medical editors in Cleveland on June 5, 1883, said:

> "It has appeared from the review of the past that, during the first twenty-five years of our national existence, laws were enacted in nearly all the then existing states designed to protect the people from the impositions of ignorant and designing men claiming power to heal the sick, by prohibiting unlicensed practice, etc.; but which were nearly all repealed or so amended as to render them inoperative during the next thirty years by means of popular prejudices and false representations attendant upon the rise and spread of Thompsonianism and homoeopathy; the one playing upon the mind of the masses with all the power of bold and ignorant empiricism, and the other captivating the credulous tendencies of the more fashionable circles by a mystic transcendentalism inclosed in sugar pellets. The first has died a natural death, leaving a sickly offspring bearing the name of eclectics, while the second, like some medicines, retains its name as a 'trade mark,' and its organization for political influence, while its once transcendental vagaries have long since practically ceased to exert an influence over the treatment of disease."

The homeopaths and eclectics, as standards of medical education improved, gradually abandoned their exclusive theories of treatment and were assimilated into medical practice.

It was not until the 1953 session of the Wisconsin Legislature, however, that the last vestiges of homeopathy and eclecticism were removed from the statutes. In that year the legislature altered the make-up of the board to eliminate the homeopathic representative.

As noted, Wisconsin first enacted the beginnings of an effective Medical Practice Act in 1897 with the establishment of a state examining board. Anyone entering medical practice following its enactment was required to be licensed by the board.

It is interesting to compare the license application requirements, then and now. An applicant had the alternative of submitting to an examination "in the various branches of medicine and surgery" or presenting to the board a diploma from a medical college which required "at least three courses, of no less than six months each, before graduation."[6] Thus practical training with a "respectable" physician remained an avenue to licensed medical practice, but the pattern of effective control of medical qualification was established.

The 1897 Act made no provision for the licensing of those already in medical practice or the date it became effective. The very next legislature required "every reputable physician of good moral character" who wished to continue in practice to register with the board and to present a diploma or other credentials. A registration certificate was then issued which was required to be filed with the county in which the physician practiced. Criminal penalties were provided for noncompliance.[8]

It was only 60 years ago, then, that the unlicensed or uncertified practice of medicine could be prohibited by criminal prosecution.

This requirement of medical license or certificate was a blow to osteopathy whose practitioners had, by this time, established themselves in Wisconsin. The legislature, in its 1901 session, added an osteopath to the board of medical examiners, provided for an examination and licensure in osteopathy, but permitted all those already in practice to continue under a typical "grandfathers" clause.[9]

This same legislature increased the requirements for medical education to four courses of not less than seven months with at least an equivalent of two years of high school and, more significantly, required both an examination and a diploma as a condition to medical license. Those presenting a diploma from a medical school in Wisconsin, however, were exempt from the examination requirement.[9] These amendments marked an end to practical experience with a preceptor as an alternative to medical school education for licensure.

As with eclecticism and homeopathy, the osteopaths gradually began to abandon their cult theory and practice. There was evidence that some of their schools were interested in and were improving their standards and facilities.

In 1949 the Medical Practice Act was amended to eliminate separate licensing of osteopaths. Thereafter licenses to practice medicine and surgery were issued, under the usual conditions, to applicants presenting diplomas from a "medical or osteopathic college with standards of education and training substantially equivalent to the University of Wisconsin Medical School, approved and reorganized by the board." [10]

Osteopaths then in licensed practice were permitted to enroll in a prescribed course in materia medica and pharmacology and, upon successfully completing an examination by the board in those subjects, received an unlimited license to practice medicine and surgery upon surrender of their old license.[10]

As has been seen, effective criminal machinery was available by 1899 to restrain and eliminate unqualified and unlicensed practice in Wisconsin. Apparently, a lack of early and forceful enforcement permitted chiropractic to gain a foothold in Wisconsin by 1915. Clearly they were engaged in medical practice for which, as today, they were incompetent

and unqualified. They were neither licensed nor certified by any state agency.

The 1915 Wisconsin Legislature passed a statute authorizing chiropractors to practice so long as they did not hold themselves out as licensed or registered —and, for good measure, gave special licensure recognition to the itinerant practitioner of medicine or osteopathy.[11]

Then, in a sharp reversal of form, the same legislature substantially increased the educational requirements upon those who applied for a license to practice medicine and surgery.[11]

This important chiropractic breakthrough seriously threatened the entire structure of those laws designed to assure that those who treated the sick in Wisconsin were qualified to do so. In effect the legislature was imposing increasingly more rigorous requirements upon those who were qualified and none whatsoever upon those who were not.

Lurking in the background at this time were the naturopaths, the naprapaths, the faith healers, quacks, charlatans and other cultists ready and eager to follow the lead of the chiropractors to unqualified legislative recognition—or exemption from educational and training requirements.

Thus, one of the significant legislative actions in the development of our Medical Practice Act was the enactment of the Basic Science Law by the 1925 Legislature. It will be considered in some detail later. Generally, however, and with some limited exemptions, it imposed minimal qualifications upon all who would treat the sick in Wisconsin. It is so inclusive in its scope that it is the law most frequently used in prosecutions against the unlicensed.[12] It has effectively subdued the quacks and all cult groups other than the chiropractors who received license recognition in the same session of the legislature.

In summary, Wisconsin joined with other states a hundred years ago in appreciating the absolute need for the imposition of adequate standards to assure qualified health care to its people. These legislative standards and the mechanisms through which they could be enforced developed and improved through the years.

Wisconsin, as did the other states, experienced the growth of cultism and potent efforts to undermine qualifying legislation which had been so painstakingly achieved. The development of these cults and the legislative treatment of them has been briefly traced. The present state of the law will now be examined in some detail.

THE BASIC SCIENCE LAW

General Provisions

In 1925, at the request of the State Medical Society of Wisconsin, the Wisconsin Legislature enacted the Basic Science Law, being the first state to do so. The majority of the states now have laws similar in purpose and effect. The Basic Science Law, which is a part of Chapter 147 of the Wisconsin Statutes, is appropriately named because it enumerates not alone the basic qualifications imposed upon those who would treat the sick, regardless of their method or system of doing so, but because it is also the basic structure upon which the health laws of Wisconsin are predicated.

The Basic Science Law does not authorize one who has successfully passed the examination to engage in any form or manner in caring for the sick. The law is intended only to afford reasonable certainty that, in the basic sciences of anatomy, physiology, pathology and physical diagnosis,[13] those who treat the sick in Wisconsin possess the minimum qualifications.

The Basic Science Law provides that no person shall treat, or attempt to treat, the sick unless he has a certificate of registration in the basic sciences.[14] But this alone does not permit a registrant to treat the sick. He must be otherwise licensed.[15] No examining board for any branch of treating the sick may license, register or admit to its examination any applicant unless he first presents a certificate of registration in the basic sciences, with the exceptions noted in the paragraphs immediately below.[16]

Specifically exempt from the operation of the Basic Science Law are commissioned surgeons of the Army, Navy, and Federal health service,[17] registered nurses,[18] dental hygienists,[19] optometrists,[20] and persons practicing Christian Science.[21] Medical or osteopathic physicians of other states or countries in actual consultation with resident licensed practitioners,[22] persons gratuitously prescribing and administering family remedies or rendering treatment in an emergency are likewise exempted.[23]

All persons who, prior to February 1, 1925 (the effective date of the Basic Science Law), were not registered or licensed to treat the sick but, on that date, were lawfully treating the sick in Wisconsin were granted the opportunity of being registered upon application to the board.[24] Thus, all persons lawfully treating the sick in Wisconsin, other than those above enumerated, must possess a basic science certificate or its equivalent.

Definition of "Treating the Sick" All Inclusive

Section 147.01 (1), Wisconsin Statutes, 1959, defines what constitutes treating the sick in Wisconsin:

> "(a) 'To treat the sick' is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts, for compensation, direct or indirect, or in the expectation thereof."
>
> "(b) 'Disease' includes any pain, injury, deformity, or physical or mental illness or departure from complete health and proper condition of the human body or any of its parts."

Even such minor departures from complete health, as astigmatism, headaches and partial paralysis,

constitute "disease" within the meaning of the Basic Science Law, and advising as to their care constitutes "treating the sick."[25] The use of roentgenography for diagnosis and treatment is treatment of the sick.[26] The use of natural forces, such as light, heat, air, water and exercise, in the treatment of disease, constitutes treating the sick within the provisions of the Basic Science Law.[27] Diagnosis and treatment of unhealthy conditions of the skin and scalp constitute treating the sick.[28]

Board of Examiners in the Basic Sciences

The State Board of Examiners in the Basic Sciences consists of three lay educators appointed by the Governor to serve for a term of six years each.[29] None of the appointees may be on the faculty of any department teaching methods of treating the sick.[30]

The board keeps a complete record of all applications, examinations, registrations, fees, decisions, orders and proceedings. It is authorized to appoint, subject to the civil service law, such competent and recognized experts as shall be necessary in examinations, as well as clerks. Their compensation, together with the compensation of board members, and all other disbursements by the board, may not exceed in amount the fees received.[31]

Application for Certificate

Application for a certificate of registration must be made to the Board of Examiners in the Basic Sciences. Such application must be accompanied by satisfactory evidence of good moral character and preliminary education equivalent to graduation from an accredited high school of this state, together with a fee of $10.[32] The applicant is not required to disclose the professional school he attended or the system of treating the sick which he intends to pursue.[33]

The preliminary high school requirement is waived only as to those applicants who were attending a professional school which was teaching the basic sciences on February 1, 1925.[34]

Basic Science Examination and Certificate

The examinations are conducted at least four times a year at times and places fixed by the board, and are both written and practical.[35] The applicant is examined in anatomy, physiology, pathology and physical diagnosis,[36] and if he achieves the grade of 75 per cent in each subject, he receives a certificate in the basic sciences signed by the president and secretary of the board. In the event the applicant fails in one subject only, he may be re-examined in that subject at any examination within one year without further fees, but if he fails in two or more, he must re-apply and be re-examined in all subjects.[37]

If the state boards of medical or dental examiners accept in whole or in part certifications from their national boards of examiners, the basic science board may accept such national certificates in lieu of their own examinations.[38]

Since a certificate in the basic sciences does not authorize one to engage in the practice of treating the sick, compliance with the law is merely a condition precedent to taking the examination of one of the licensing boards. The Basic Science Law in no manner supplants conditions imposed by the various licensing boards.[39]

Reciprocity

The board may issue a certificate to an applicant who presents satisfactory evidence of having passed examination in the basic sciences before a legal examining board or officer of another state, or of a foreign country, if the standards are as high as those of this state, and upon the payment of a fee of $15.[40]

Court Review

The action of the board in granting or denying a certificate is subject to review by appeal in the manner provided in Chapter 227, Wisconsin Statutes. The applicant affected, or any state examining board for any branch of treating the sick, may take such appeal.[41]

The court may then affirm, reverse, or modify the decision of the board.[42]

Revocation

A certificate of registration in the basic sciences is subject to revocation for the causes and in the manner provided in Section 147.20, Wisconsin Statutes.[43] For discussion of that section and procedure under it see "Revocation or Suspension of License," page 11, of this article.

Enforcement of the Basic Science Law

The definitions of "treat the sick" and of "disease" are sufficiently broad to encompass even the "hair restorer" and the "headache reliever" as has been seen. All who "treat the sick" are required to have a certificate in the basic sciences with the noted exceptions.

Of equal importance is the fact that the law is readily enforceable. In addition to a criminal penalty of a fine or imprisonment,[44] the board of medical examiners or the district attorney of the proper county may bring action in the name and on behalf of the state to enjoin a violation.[45] It has been the latter procedure which has proved most effective.

LICENSING REQUIREMENTS AND PROCEDURES

As has been noted, a basic science certificate does not entitle its holder to treat the sick. This is further clarified in Section 147.14 (1), Wisconsin Statutes, 1959:

"**147.14. Practice.** (1) No person shall practice or attempt or hold himself out as authorized to practice medicine, surgery, or osteopathy, or any other system of treating the sick as the term 'treat the sick' is defined in s. 147.01 (1) (a), without license or certificate of registration from the state board of medical examiners, except as otherwise specifically provided by statute."

Several exceptions to this provision are created by virtue of a statutory provision that exempts those engaged in healing the sick through Christian Science,[47] while still another provision exempts from licensure requirements those engaged as commissioned officers of the Army, Navy, or Federal public health service, or licensed practitioners in medicine and surgery or osteopathy and surgery of other states or countries who may be in actual consultation with resident licensed practitioners of this state. Nor does this law apply to gratuitous prescribing and administering of family remedies, or to treatment rendered in an emergency.[48]

Still others are exempt from the provisions of this section by reason of their compliance with other specific licensing statutes, such as those dealing with chiropractic and optometry.

However, there is no "No Man's Land" in licensure in Wisconsin. Specific theories or systems of treating the sick not recognized in Wisconsin may not be pursued as a vocation. This includes such cultists as naturopaths, naprapaths, and others. To treat the sick in Wisconsin, one must be licensed specifically to exercise that privilege under the Wisconsin licensure law.[49]

Each specific licensed field in Wisconsin is under the jurisdiction of one of the several licensing boards. The State Board of Medical Examiners licenses applicants for the practice of medicine and surgery, physical therapy, and chiropody.

Other than medicine and surgery, each licensed field of practice is limited by law either in the scope of its practice or in the modalities or treatment methods it may apply. It is not the purpose of this article to set forth those limitations. Licensure requirements, application procedures, powers and organizations of the respective licensing boards, license revocation and disciplinary procedures will be treated, however, as will statutory provisions of particular interest and importance to the particular field of practice involved.

MEDICINE AND SURGERY

Examining Board

The examining body for applicants for license to practice medicine and surgery is the state board of medical examiners, which is composed of eight licentiates, one of whom must be an osteopath, appointed by the governor for four-year terms.[50] No instructor, stockholder, member of, or persons financially interested in any school having a medical or osteopathic department, is eligible.[51]

The board has its permanent office in Madison and is required to meet at least four times a year, one meeting of which must be on the second Tuesday of January at Madison for the purpose of electing its officers.[52]

It keeps a register of the applications it receives and the licenses and certificates of registration issued.[53]

All persons licensed or registered by the board are required to register with it annually and pay the required fee. These include those licensed to practice medicine and surgery;[54] the osteopaths,[55] the chiropodists or podiatrists,[56] and the physical therapists.[57]

This annual re-registration requirement must be complied with in January of each year and the board is required to publish a printed list of all registrants before March 11 and mail a copy to each registrant and to designate law enforcement officials including the sheriff and district attorney of each county.[58]

All applications for licensure from the board must be presented at the time and place designated by it.[59] In this connection, the board in the exercise of its inherent rule-making authority, has adopted a wide range of regulations detailing its specific requirements as to the procedure in making application for licensure.[60] These are subject to frequent change; therefore, it is suggested that specific inquiry be directed to the offices of the State Board of Medical Examiners, State Capitol Building, Madison, Wisconsin.

Educational Requirements

The minimal educational requirements of an applicant for license to practice medicine and surgery are summarized in Table 1, Column 1, page 8.

The medical or osteopathic college from which the applicant has graduated must be "substantially equivalent" in its standards of education and training to the University of Wisconsin Medical School and approved and recognized by the board on this basis.[61]

Inquiry as to whether a particular college has been approved should be directed to the office of the board. As to colleges not already approved and recognized, the board or a designated agent is required to conduct an investigation and a public hearing with notice to all interested parties.[62]

Examination and Licensure

The State Board of Medical Examiners examines all applicants in subjects usually taught in a reputable medical school.[63] The board, if six of its members find the applicant qualified, then issues a license to practice medicine and surgery, signed by the president and secretary, and attested by the seal of the board.[64]

TABLE 1—*Requirements of an Applicant for a License in Medicine and Surgery, Chiropody, Chiropractic, Optometry, Dentistry and Nursing*

Applicant for License in	Preliminary	Undergraduate	Professional and Personal	Additional Requirements	Application Fee
Medicine and Surgery (Secs. 147.15; 147.17(1))	Equivalent to graduation from an accredited high school of this state.	Equivalent to the premedical course at the University of Wisconsin, including physics, chemistry and biology.	Good moral and professional character; diploma from reputable professional college with standards of education and training substantially equivalent to the University of Wisconsin Medical School.	If not required by the professional school for graduation, internship of at least 12 months in a reputable hospital; a verified statement of familiarity with health requirements on communicable diseases.	$45, with an additional $5 if license issued.
Chiropody (Sec. 154.02)	After July 1, 1926, an equivalent to graduation from an accredited high school of this state.	One year in a recognized college of liberal arts or science, since July 1, 1940.	Completion in a reputable school of chiropody, a course, at least equivalent to 3 years of 37 weeks of class hours each, in anatomy and physiology of the feet, and diagnosis of the foot ailments and deformities which the chiropodist is authorized to treat, materia-medica, chiropodial orthopedics, bacteriology, pathology, histology, therapeutic chemistry, and minor surgery and bandaging pertaining to ailments of the feet, and the mechanical treatment of congenital or acquired deformities of the feet. Applicant must be of good moral and professional character and more than 21 years of age. After July 1, 1950, no degree which entitles one to practice chiropody shall be accepted from any recognized university or college of chiropody except that of "Doctor of Chiropody." Any school conferring the "DSC" degree must have a professional curriculum of 4 years, with at least 32 weeks and at least 30 class hours each week, with adequate clinical or hospital facilities.	None.	$25
Chiropractic (Sec. 147.23(3))	None	2 years of study for a Bachelor of Arts or Science degree in a college accredited by the North Central Association of Colleges and Secondary Schools.	Graduation from a reputable school of Chiropractic, approved and recognized by the Board of Examiners in Chiropractic, having a residence course of not less than 36 months, consisting of not less than 3,600 60-minute class periods. Satisfactory evidence of good moral character.	Certificate of Registration in basic sciences.	$25
Optometry (Secs. 153.04 and 153.05)	None	None	Good moral character, 21 years old. Graduation from an accredited college of optometry approved and recognized by Optometry Board, and 5 years approved training in optometry, of which 3 years must have been in an accredited school or college of optometry.		$35 for resident $50 for non-resident. $10 for subsequent examination in event of failure.
Dentistry (Sec. 152.03)	Equivalent to graduation from a high school or academy in Wisconsin offering a four-year curriculum beyond the 8th grade.	2 years college preparation leading to a baccalaureate degree including English and the sciences, physics, biology and chemistry.	Satisfactory completion of dental school and college recognized by the Wisconsin State Board or Dental Examiners with a curriculum of at least four years of 52 weeks each.		$25
Nursing (a) Registered Nurse Sec. 149.04	Equivalent to high school education.		Good moral character, citizen, or intends to be citizen. Diploma of graduation from an accredited school of nursing.		$25
(b) Practical Nurse Sec. 149.09(2)	2 years of high school or equivalent.		Good moral character, citizen, or intends to be citizen, 18 years of age. Completed work prescribed by an accredited school for trained practical nurses approved by the board.		$15

Licensure without Examination

The board may license without examination a person holding a license to practice medicine and surgery in another state, if in such state the requirements imposed are equivalent to those of this state, upon presentation of the license and a diploma from a reputable professional college approved and recognized by the board, or an honorably discharged surgeon of the Army or Navy, or of the Federal public health service, upon filing of a sworn and authenticated copy of his discharge.[65]

Applicants from Unapproved Foreign Medical Schools

As has been noted, an applicant for a license to practice medicine and surgery must present to the board of medical examiners a diploma from a medical or osteopathic college *approved and recognized by the board.* A number of foreign medical schools are not. Some which are, have that approval only during specified graduating years.

A carefully restricted opportunity for applicants who cannot present a diploma from such an approved school was provided by the 1957 session of the Wisconsin Legislature.[66]

If the board is persuaded that a graduate of an unapproved and unrecognized foreign medical school has preprofessional and professional training substantially equivalent to that offered by the University of Wisconsin premedical and medical schools, it may admit the applicant to examination and issue a license to practice medicine and surgery.

Before it can do so, however, the board must submit to the dean of a medical school, which has been approved by the board, the question of substantial equivalency. Only if that dean states in writing that the foreign graduate's premedical and medical training is substantially equivalent to that offered by the University of Wisconsin, can the board admit that applicant to examination and possible licensure status.[67]

Only 25 licenses a year may be issued to such applicants and, unless extended by the 1961 Legislature, the law creating this exemption from regular educational requirements will expire on July 1, 1961.

Temporary Licenses to Practice Medicine and Surgery

Several months may elapse between the time an obviously qualified physician applies for a Wisconsin license and the board conducts its next examination.

Provision has been made by statute under which any two officers of the board of medical examiners may cause to be issued a temporary license to practice medicine and surgery to such an applicant.[68]

Two such officers must first find, however, that an emergency need for medical personnel in a particular area exists and the temporary license must limit its holder to practice in that area.

This statute contemplates that the temporary licensee will submit to the next board examination for permanent license. To that end a temporary license expires within 30 days after the next examination for permanent license is conducted by the board or on the date the board grants or denies the applicant a license—whichever date first occurs. If the temporary licensee does not take the examination, the license expires on the day the board begins its examination of applicants.[69]

A temporary license may be issued only once to the same person; and, during the period it is in force, the basic science law certificate requirement is suspended, assuming the temporary licensee has applied for a basic science certificate and the application has been accepted by the basic science board.

This provision for temporary licenses, unless extended by a subsequent legislature, will expire on June 30, 1963.

Temporary Educational Certificates in Medicine and Surgery

For the stated single purpose of providing opportunities in Wisconsin for the postgraduate education of certain persons in medicine and surgery who do not possess a license and, presumably, are not eligible for one, the board of medical examiners may issue educational certificates under prescribed conditions.[70]

An applicant for such a certificate must have training in medicine and surgery satisfactory to the board. It may be issued for a period not to exceed one year. It may be renewed annually, at the discretion of the board, for not more than four additional years. No more than 50 temporary educational certificates can be issued annually and no more than 150 may be outstanding at any one time.[71]

Limitations on Practice

The certificate permits its holders to take postgraduate educational training only in a teaching hospital which maintains standards prescribed by the board and are commensurate with those of nationally recognized accrediting organizations. He may render services to patients only under the direction of a person licensed to practice medicine and surgery in Wisconsin.

Under such medical direction, the educational certificate holder may prescribe drugs other than narcotics and sign certificates, reports and other papers required, or for the use of public authorities which are required of or permitted to one licensed to practice medicine and surgery.

Additional restrictions are these: The certificate holder must confine his training and practice within the hospital in which he is taking his postgraduate education, and neither he nor the hospital may receive fees or other income for his services from any patients treated by him.[72]

The Status of Externs, Interns and Residents

Externs

The term "extern" or "preceptee" refers to advanced medical students in their clinical years, who have not as yet completed their college course in medicine. A preceptee performs certain assisting and observing functions, either during a vacation period, or during his fourth year of medical study, under the supervision of a licensed physician. Preceptees participate in this portion of their training under an arrangement between supervising physicians and the medical school. The hospital has no jurisdiction over them.

A preceptee is generally an assistant to a physician. The duties delegated to a preceptee by a physician are usually very much limited and relate only to observation. Thus, a situation would seldom arise in which an act of a preceptee might cause injury. A physician presumably has the duty to see to it that the preceptee is delegated no duty which would call for discretion or judgment on his part. However, a negligent act on the part of a preceptee in the treatment of a patient is a responsibility of the physician under whom he is working.

Interns

An "intern" is generally understood to mean one who is engaged in a twelve months' period of advanced study immediately subsequent to the completion of his college course and prior to the granting of his medical license. Internship is a prerequisite for the granting of a license to practice medicine and surgery in Wisconsin. After one year of internship, unless his medical school requires a longer period of internship as a condition of graduation, the intern must be licensed and have the legal status of a practicing physician.

An intern does not have the full legal status of a licensed practitioner. He does have certain functions of a medical nature which he is permitted to perform. The Wisconsin Supreme Court has admitted that interns are not subject to the Medical Practice Act because the Wisconsin Statutes require an internship as a part of one's medical education prior to licensure. The court summarized the legal status of an intern in Wisconsin as follows:

> "This is a legal sanction of the performance of such duties on the part of interns as are usually and ordinarily performed by them. The performance of such duties does not constitute the practice of medicine, or a representation

that the intern is authorized to practice medicine." [73]

Interns are not within the provisions of the so-called "medical privilege statute."

When it comes to responsibility for negligence of interns while performing their customary duties, it is clear that they have a personal responsibility. The responsibility for their acts, however, may extend to the physicians under whom they are working, or to the hospital employing them. The law generally holds the intern to be an employee or servant, inasmuch as he is obliged to spend his days and nights at the hospital to render any administrative or medical service provided by the hospital through its agents, within the range prescribed by propriety and custom. This interpretation of his position is recognized by the courts under the Workmen's Compensation Act, which extends employee protection to interns injured in the performance of their duties in the hospital.

Wisconsin has held that the hospital is responsible for liability arising out of the acts of interns in the performance of duties which are customarily performed by them. However, where the intern is acting under the direct supervision of a physician during the course of an operation, the hospital is absolved from responsibility and his acts become those of the physician who has charge of the work.

Residents

A "resident" is usually understood to mean a physician engaged in postgraduate medical education beyond the period of internship, and under the supervision of a hospital medical staff or a medical faculty. A resident is required by Wisconsin law to hold a regular, permanent license to practice medicine. He is as fully responsible for his acts or omissions as any other licensed practitioner.

Itinerants

The following statute specifically governs licensure of the itinerant practitioner to practice any form or system of treating the afflicted:

> "**147.18 Itinerants.** Itinerant practitioners of medicine, surgery or osteopathy or of any form or system of treating the afflicted shall obtain an annual license in addition to the regular license or certificate of registration, and shall pay therefor two hundred fifty dollars per annum. Persons practicing medicine, surgery or osteopathy or professing or attempting to treat or heal ailments or injuries of the human body who go from place to place at regular or irregular intervals less frequently than once a week, are itinerant practitioners."

Revocation or Suspension of License

Three procedures have been established by statute for the revocation or suspension of a license or certificate issued by the Wisconsin State Board of Medical Examiners:

By Civil Action

The district attorney is authorized to bring civil action in circuit court against the holder of a license to practice medicine and surgery and in the name of the state to revoke or suspend his license upon a verified complaint received by him charging the holder of the license with having been guilty of immoral or unprofessional conduct, or with having obtained a license by fraud, perjury or error.[74] The same subsection sets out certain other procedural features of such a suit.

The words "immoral or unprofessional conduct" are defined by section 147.20 (1), as follows:

> "(a) Procuring, aiding or abetting a criminal abortion; (b) advertising in any manner either in his own name or under the name of another person or concern, actual or pretended, in any newspaper, pamphlet, circular, or other written or printed paper or document the curing of venereal diseases, the restoration of 'lost manhood,' the treatment and curing of private diseases peculiar to men or women, or the advertising or holding himself out to the public in any manner as a specialist in diseases of the sexual organs, or diseases caused by sexual weakness, self-abuse or excessive indulgences, or in any diseases of a like nature or produced by a like cause, or the advertising of any medicine or any means whatever whereby the monthly periods of women can be regulated or the menses re-established, if suppressed, or being employed by or in the service of any person, or concern, actual or pretended so advertising; (c) the obtaining of any fee, or offering to accept a fee on the assurance or promise that a manifestly incurable disease can be or will be permanently cured; (d) wilfully betraying a professional secret; (e) indulging in the drug habit; (f) conviction of an offense involving moral turpitude; (g) engaging in conduct unbecoming a person licensed to practice or detrimental to the best interests of the public."

The license of a physician who attempts to perform an abortion may be revoked or suspended, and the fact that he was acquitted of the same charge in a criminal action does not bar a proceeding under this section.[75] Nor is the time within which to bring such action, after the offense has been committed, important.[76] The attorney general has further ruled that a physician who directed a patient to an abortionist who did, in fact, perform an abortion, is guilty as an accessory before the fact, and his license is subject to revocation or suspension under this section.[77]

Subject to the limitation that any act in question must occur in the course of professional conduct, defrauding through use of the mails has been ruled to be a crime involving moral turpitude under section 147.20, while violation of the Federal Narcotic Act probably is not; indulgence in a drug habit is immoral or unprofessional conduct under section 147.20.[78]

By Action of the Board

The statute also provides that when any person licensed by the State Board of Medical Examiners is convicted of a crime committed in the course of his professional conduct, the clerk of the court shall file with the board a certified copy of the information and of the verdict and judgment; and upon such filing the board shall revoke or suspend

the license or certificate. The board is likewise under a duty to revoke or suspend any such license or certificate upon proof of a Federal conviction of a crime committed in the course of the holder's professional conduct.[79]

The license of a physician who has been convicted of a crime cannot be revoked or suspended by the board unless the crime was committed in the course of his professional conduct. If the crime of which the person is convicted, however, involves moral turpitude, the license may be revoked or suspended by a circuit court action described in part (a) of this section.[80]

Revocation or suspension of a license under this section requires affirmative action by the board, and the right to practice continues until such action is taken.[81] There is no time limitation within which the board must act. In the event, however, that the board suspends rather than revokes the license or certificate, the suspension must be for a definite period not exceeding two years, and the board has the power, upon a proper showing, to restore it at any time within the period.[82]

The board has no authority to restore a revoked license.[83] It may be restored only after a first revocation, and then only by subsequent order of the trial court upon notice to the district attorney who prosecuted, or in the event of his disability, his successor in office, and upon written recommendation of the president of the State Board of Medical Examiners with a finding by the court that the applicant is of good moral and professional character and that justice demands the restoration.[84]

State Medical Grievance Committee

In 1935 there was enacted the section quoted below.[85] It was designed to provide a body of qualified public officers to investigate, hear, and act upon practices by persons licensed to practice medicine and surgery which are inimical to the public health. The statute follows:

> "**147.195. State medical grievance committee.** The state health officer, the secretary of the state board of medical examiners, and the attorney general or deputy attorney general or their representatives, are hereby constituted ex officio a state medical grievance committee, to investigate, hear, and act upon practices by persons licensed to practice medicine and surgery under 147.17, that are inimical to the public health. The state health officer shall be chairman of the committee. Meetings of the committee shall be held at the call of the chairman. Any member thereof shall have power to subpoena and swear witnesses, and take evidence. The committee shall have power to warn and to reprimand, when they find such practice, and to institute criminal action or action to revoke license when they find also probable cause therefor under criminal or revocation statute, and the attorney general may aid the district attorney in the prosecution thereof. The records of said committee shall be kept by and be in the custody of the chairman thereof. No member of said committee shall receive any extra compensation therefor, nor other than his actual expenditures in attending upon his duties thereon. All divisions, officials and employees of state and local government are authorized to cooperate with the committee in conducting investigations and by making available to it pertinent data in their possession."

MASSAGE AND HYDROTHERAPY

The 1953 session of the Wisconsin Legislature repealed that section of the statutes which authorized the registration of masseurs by the state board of medical examiners.[86] It permitted those previously registered to continue in practice under the same conditions and limitations as were imposed by law prior to the repealer.[87] Because there are a number of these "grandfathers" still in practice in Wisconsin, the nature and scope of their authorized practice are set forth.

Limitations on Practice

Masseurs are not permitted to treat a specific disease except upon the advice of a licensed medical physician.[88] Assuming such advice, the masseur is limited to the practice of massage, hydrotherapy and educational gymnastics in his treatment.[89] He may use a galvanic generator, diathermy, infra-red ray, and ultra-violet light for massage purposes.[90]

An opinion of the attorney general defines "massage and hydrotherapy" as: "A method of rubbing, kneading, or stroking of the superficial parts of the body by the hand or an instrument, for the purpose of modifying nutrition, restoring power of movement, breaking up adhesions, etc., and hydrotherapy is the treatment of disease by means of water."[91]

PHYSICAL THERAPY

With the elimination of further registrations in massage and hydrotherapy, the 1953 session of the Wisconsin Legislature, which enacted the masseur repealer, recognized the growth, acceptance, training and education of the qualified physical therapist. It provided authority in the state board of medical examiners to accept applications from physical therapists meeting stated qualifications; to conduct examinations through a committee of physical therapists appointed by it; and to issue certificates of registration to successful applicants.[92]

Physical therapy is defined, by statute, as treatment utilizing "physical, chemical and other properties of heat or cold, light, water, electricity, massage and therapeutic exercises, including posture and rehabilitation procedures.[93]

Limitations on Practice

Physical therapy, as above defined, is a part of the practice of medicine and some other licensed or registered practices in Wisconsin. Persons licensed or registered in this state, under another law, to engage in a practice which includes physical therapy are not affected by the legal limitations imposed upon it.[94]

All other persons practicing physical therapy or adopting titles, such as "physical therapy technician," must be registered by the state board of medical examiners.[95]

There are further restrictions on the practice. The registered physical therapist may not use Roentgen rays or radium for any purposes nor may he use electricity for surgical purposes, including cauterization.[96] And, most significantly, he may not undertake treatment unless it be under a prescription and the direct supervision of a person licensed to practice medicine and surgery.[97]

OSTEOPATHY

Osteopaths are no longer licensed as such in Wisconsin. In recent years the Wisconsin Legislature became convinced that osteopathy, as with homeopathy, had abandoned its cult background and therapy. It enacted legislation providing that if an applicant presented to the state board of medical examiners a diploma from an osteopathic college *with standards of education and training substantially equivalent to the University of Wisconsin Medical School* and which school was approved by the board, a license to practice medicine and surgery would be issued. This is conditioned, of course, upon the applicant meeting all other prequalification requirements for medical licensure including examination.[98] These are set forth in the table appearing at page 8.

Provision was made in the same legislative enactment through which those osteopaths, previously licensed by the board to practice osteopathy and surgery, could qualify for the unlimited license to practice medicine and surgery. Seeking the unlimited license, the osteopath is required to take a prescribed course, approved by the board of medical examiners, in materia medica and pharmacology and to pass the same examination in the subjects as given to a medical school graduate at any regular meeting of the board.[99]

Limitations on Practice

The graduate of an osteopathic school who holds a license to practice medicine and surgery is prohibited from using the title "doctor of medicine" or the letters "M.D."[100] Other than that his license to practice medicine and surgery is identical in its unlimited privileges as that of the doctor of medicine.

There are a sufficient number of osteopaths, licensed as such, and still in practice, who did not seek or gain the unlimited license to warrant a brief statement of the limitations imposed upon their practice.

Osteopathy is frequently defined as a form of "manual treatment of disease." It is a system of therapy without the use of drugs, based on the theory that diseases are chiefly due to mechanical derangement in the structure of the human body, which can be remedied by manipulation.[101]

Under the accepted principle that osteopaths are licensed to practice only "osteopathy and surgery" and not "medicine and surgery," the attorney general has issued numerous opinions confining the practice of osteopathy to its own system or philosophy of treating the sick.[102] Thus it has been ruled by the attorney general that an osteopath cannot prescribe medicines except those necessary as a part of an actual surgical operation.[103]

Persons licensed to practice osteopathy and surgery may not enlarge the legal scope of their activities merely by undertaking to perform functions properly belonging to the practice of medicine alone. Since vaccination, and the use of serums, antitoxins and the like is a form of preventive medicine, an osteopath is forbidden their use in his practice, for, according to the attorney general, "The point is that if an osteopath is qualified to practice medicine he may become licensed to do so. . ."[104]

CHIROPODY

The practice of chiropody, or podiatry as its practitioners prefer it to be designated, has been legislatively recognized and controlled in Wisconsin since 1917. Its practitioners are registered by the state board of medical examiners after the applicant meets the prequalification requirements outlined in the table appearing at page 8, and successfully passes an examination conducted by three licensed chiropodists appointed by the board.[105]

The scope of chiropody practice is defined by statute:

> "(1) The practice of chiropody is the diagnosis or mechanical or surgical treatment, or treatment by the local application of drugs, of the feet, but does not include amputations, or surgical operations upon the feet for congenital or acquired deformities or conditions requiring the use of an anesthetic other than local, nor treatment of any portion or organ of the body above the feet, except that the diagnosis and mechanical treatment shall include the tendons and muscles of the lower leg insofar only as they shall be involved in the conditions of the feet. Nothing herein contained shall be construed to permit major surgical operations upon the foot, nor minor operations upon the foot involving vascular diseases or diabetes except upon the advice of one licensed under s. 147.17, nor the treatment of conditions of the feet involving osteomyelitis, malignancies or syphilis, nor the therapeutic use of X-ray and radium, nor cutting operations directed primarily towards the treatment or correction of afflictions of the bones, ligaments, muscles, nerves or tendons of the feet."[106]

Although no one is permitted to practice chiropody unless registered as such by the board of medical examiners, physicians are specifically exempted.[107]

CHIROPRACTIC

The practice of chiropractic has been licensed in Wisconsin since 1925. It has its own licensing board consisting of three chiropractors, appointed by the Governor with the advice and consent of the Senate.[108]

An applicant for chiropractic license must present to the board a certificate of registration in the basic sciences and otherwise meet the prequalification requirements outlined in the table appearing at page 8.[109]

The theory of chiropractic is set forth in rules which have been adopted by the State Board of Examiners in Chiropractic. It is based on the premise that disease or abnormal function is caused by interference with the normal nerve transmission and expression, due primarily to pressure, strain, irritation or tension upon the spinal nerves as they emit from the spinal column, as a result of bony segments, especially of the spine, deviating from their normal juxtaposition.[110]

Limitations on Practice

The practice of chiropractic is defined by board rule. It provides as follows:

> "The practice of chiropractic consists of the analysis of any interference with normal nerve transmission and expression and the correction thereof by a specific adjustment with the hands of the abnormal deviations of the bony articulations especially of the spine, for the removal of the cause of disease, without the use of drugs or surgery. The term, analysis, is construed to include the use of x-ray and other analytical instruments generally used in the practice of chiropractic." [111]

OPTOMETRY

Optometrists are licensed in Wisconsin by a board of five members, appointed by the Governor, and designated the Wisconsin Board of Examiners in Optometry.[112] An applicant for a license in optometry must meet the prequalification requirements outlined in the table appearing at page 8, and successfully pass an examination conducted by the board. No basic science certificate is required. [113]

Limitations on Practice

Optometry is defined as:

> "The practice of optometry is defined as follows: The employment of any means other than drugs to determine the visual efficiency of human eyes or the measurement of the powers or defects of vision; the furnishing, using or employment of any means or device designed or calculated to aid in the selection or fitting of spectacles or eyeglasses; and the adaptation of lenses, prisms and mechanical therapy to aid the vision of any person."[114]

The practice of optometry is the employment of any means, other than the use of drugs, for the measurement of the powers of vision and the adaptation of lenses, prisms and mechanical therapy for the aid thereof.[115] It is a mechanical trade, not a profession. The legislature "has dealt with optometry as a skilled calling, not as a profession involving a relation of special confidence between practitioner and patient. [116]

No one is permitted to practice optometry, as it is defined above, unless he has been licensed by the Board of Examiners in Optometry.[117] Physicians are excepted, however.[118] So too are dispensing opticians to the limited extent that they may take necessary facial measurements and process, fit and adjust mountings, frames, lenses and kindred products in the filling of prescriptions of duly licensed physicians or optometrists for ophthalmic lenses. They may also duplicate or replace lenses without a prescription in those instances where "optometric service" is not required. [119]

ENFORCEMENT OF THE MEDICAL PRACTICE ACT

The obligation of enforcing the Medical Practice Act has been that of the State Board of Medical Examiners for almost 20 years.[120] Enforcement funds are secured from the annual re-registration fee paid to the board by its licensees and registrants.

Both criminal and civil remedies are available to the board. Violations of the Medical Practice Act call for a fine of not less than $100 nor more than $500, or imprisonment for not less than 60 days nor more than one year, or both. [121]

The civil remedy is that of injunction. The board or the District Attorney of the proper county may investigate alleged violations and bring action in the name and in behalf of the State of Wisconsin against a violator to enjoin him from further violations. [122]

CITATIONS

Note: All references below, beginning with the abbreviation "Sec." are from the designated chapters and sections of the 1959 Wisconsin Statutes. References containing the abbreviation "Wis." are from the designated volume and page of decisions of the supreme court of Wisconsin. References containing the abbreviations "Atty. Gen." are from the designated volume and pages of the official opinions of the Attorney General of Wisconsin.

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2. Report of Committee on Medical Education, *Transactions of the AMA*, 1848.
3. *A History of the AMA*, p. 22
4. *A History of the AMA*, p. 154
5. *A History of the AMA*, p. 250
6. Chapter 264, Laws of 1897
7. *A History of the AMA*, p. 111
8. Chapter 87, Laws of 1899
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10. Chapter 431, Laws of 1949
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29. Sec. 147.03
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32. Sec. 147.05
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41. Sec. 147.11
42. Sec. 227.20 (1)
43. Sec. 147.10
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47. Sec. 147.19 (2)
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57. Sec. 147.185 (4)
58. Sec. 147.175 (1), (3)
59. Sec. 147.15
60. Ibid; Wisconsin Administrative Code, Med 1.01–40.08
61. Sec. 147.15
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63. Sec. 147.16
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65. Ibid
66. Sec. 147.15 (1m)
67. Ibid
68. Sec. 147.15 (2)
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71. Sec. 147.151 (1)
72. Ibid
73. Nickley vs. Eisenberg (1931) 206 Wis. 265, 269–270
74. Sec. 147.20 (2)
75. 12 Atty Gen. 144; State vs. Lewis 164 Wis. 363
76. State vs. Schaeffer, 129 Wis. 459, 467
77. 24 Atty. Gen. 108
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82. Sec. 147.20 (5)
83. 2 Atty. Gen. 571
84. Sec. 147.20 (4); 22 Atty. Gen. 942
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86. Chap. 411, Laws of 1953
87. Sec. 147.185 (6)
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90. Sec. 147.185 (6)
91. 28 Atty. Gen. 685–686
92. Chap. 411, Laws of 1953; Sec. 147.185
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94. Sec. 147.185 (1) (b)
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96. Sec. 147.185 (1) (a)
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117. Sec. 153.02 (1)
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121. Sec. 147.21
122. Sec. 147.205 (1)

THE INFLAMMATORY REACTION—A FILM

As a part of the continuing program to provide motion pictures of interest to physicians, Lederle Laboratories offers a scientific motion picture on some new concepts concerning the inflammatory reaction. The film, "The Inflammatory Reaction," was produced in order to explain some of the complex mechanisms which initiate, regulate and limit inflammation.

The film opens with a series of pictures of actual patients and reviews, briefly, the major factors that cause the body to respond defensively to an injury by means of inflammation. What even the microscope cannot see, is shown in animated drawings, which illustrate how newly discovered chemical substances control the inflammatory reaction. Another scene describes the new concept of the physiology of the surgical barrier once thought to be impermeable, but now considered a partially permeable membrane which transmits white cells, antibiotics, and other substances. At the end of the film a short trailer discusses the medical and therapeutic aspects of inflammation.

"The Inflammatory Reaction" may be used as a visual refresher for the practicing physician. The film can also be used as a medical teaching aid. It is approximately 650 feet or 19 minutes in length. The trailer is approximately 275 feet or 7 minutes in length. All parts of the film are in color and sound.

Technical films from the Lederle Film Library are loaned without charge to medical societies, hospitals, medical schools, nursing schools, schools of pharmacy, public health departments and other allied groups. To arrange bookings, a responsible officer of the organization or institution should write directly to: Film Library, Lederle Laboratories, Division of American Cyanamid Company, Pearl River, New York. (Booking requests should be received at least two weeks prior to showing date.)

The Right to Use the Title "Doctor" in Wisconsin

HISTORICALLY, the title "doctor" has been conferred upon those who have become so well versed in a particular field of knowledge that recognized schools of higher education regard them as qualified to teach. Among the long-established doctoral degrees are those in medicine, dentistry, divinity, law, science, philosophy, letters and music.

TRADITIONALLY, when the treatment of the sick was involved, the title "doctor" has referred to the doctor of medicine.

The right to use the title "doctor" outside the field of treating the sick is not discussed. Obvious examples are doctors of divinity, veterinary medicine, or philosophy, so long as none of them is engaged in "treating the sick," as this term is defined in Wisconsin.

LEGALLY, this concept is generally followed, with Wisconsin statutes and court interpretations becoming rather specific on who may use the title "doctor."

The following is a summary of the present law of Wisconsin as it applies to the right to use the title "doctor" when engaged in "treating the sick" in the state. This is accompanied by brief references to the legal authority supporting the conclusions. It is assumed in each instance that the practitioner has fulfilled licensure or other requirements imposed by Wisconsin law.

Subsections (a) and (b) of Sec. 147.01 (1) of the Wisconsin Statutes, 1957, provide:

> "(a) To "treat the sick" is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts, for compensation, direct or indirect, or in the expectation thereof.
>
> (b) "Disease" includes any pain, injury, deformity, or physical or mental illness or departure from complete health and proper condition of the human body or any of its parts."

LEGAL AUTHORITY

The following is a summary of the principal statute or court decision which is the basis of the conclusions reached in the chart below and which follows the same order as the chart:

1. **Physician:** The right of a doctor of medicine to use the title without restriction is conferred by Sec. 147.14 (3), Wisconsin Statutes, which provides:

SUMMARY OF WISCONSIN LAW ON USE OF TITLE "DOCTOR"

Practitioner	Unrestricted Right to Public Use of Title:	Restricted Right to Public Use of Title:	No Right to Public Use of Title:
1. Physician	X		
2. Osteopath	X		
3. Dentist	X		
4. Chiropodist (Podiatrist)		X	
5. Chiropractor			X
6. Optometrist			X
7. Doctor of Philosophy (when treating the sick)			X

"(3) No person not possessing a license to practice medicine and surgery, osteopathy, or osteopathy and surgery, under s. 147.17, shall use or assume the title "doctor" or append to his name the words or letters "doctor," "Dr.," "specialist," "M.D.," "D.O." or any other title, letters or designation which represents or may tend to represent him as a doctor in any branch of treating the sick."

2. **Osteopath:** Controlled by the above subsection and, therefore, unlimited.

3. **Dentist:** The right of a licensed doctor of dental surgery to use the title without restriction is conferred by Sec. 152.02 (1), Wisconsin Statutes, which provides in part:

"(1) One who was engaged in the lawful practice of dentistry in this state on January 1, 1939, may continue if he has annually registered. No other person shall practice dentistry in this state, unless he is licensed and annually registered in the state of Wisconsin. Any person shall be said to be practicing dentistry within the meaning of this chapter who uses or permits to be used, directly or indirectly, for a profit or otherwise for himself or for any other person, the title "doctor", "Dr.", "Doctor of Dental Surgery", or "D.D.S.", or any other letters, titles, terms or descriptive matter, personal or not, which directly or indirectly represent him to be engaged in the practice of dentistry; . . ."

4. **Chiropodist:** Subsection (2) of Sec. 154.01, Wisconsin Statutes, quoted in part below, limits the right to use of the professional title of a chiropodist. That same subsection exempts a physician from the statutory restriction. The pertinent portion of the subsection provides:

"(2) No person shall practice chiropody, for compensation, direct or indirect, or in the expectation thereof, or attempt to do so, or designate himself a registered chiropodist, or use the title "R.C.", "D.S.C.", or "Doctor of Surgical Chiropody", or other title or letter indicating that he is a chiropodist, or otherwise directly or indirectly represent or hold himself out as such, unless registered by the State Board of Medical Examiners and the certificate recorded."

Thus the chiropodist has a restricted right to public use of the titles "R.C.", "D.S.C.", or "Doctor of Surgical Chiropody", but not to the independent or separate use of the title "doctor" or anything indicating the right to use such title.

5. **Chiropractor:** No statute relating to chiropractic authorizes the use of the title "doctor" or initials "Dr." or "D.C." by a chiropractor. The illegality of the use of either the title or the initials "D.C." is based upon Sec. 147.14 (3) quoted earlier in Section 1. of this article, inasmuch as chiropractors "treat the sick."

In *State v. Michaels*, (1938), 226 Wis. 574, the Supreme Court, in an opinion written by Chief Justice Rosenberry, forbade a chiropractor to use the title "doctor." The opinion stated, at pages 578 and 579, that since 1881 the word "doctor" had been restricted by the Wisconsin legislature, and that the right to use the term had become associated with those entitled to practice medicine, surgery, and after 1903, osteopathy.

With reference to the statute regulating chiropractic, which was amended in 1925 to require licensure, the court stated at page 579 of the above opinion:

"The statute was rewritten and revised to make it clear that those practicing chiropractic could not hold themselves out as a doctor or append to their names the title of doctor because, in Wisconsin at least, that would tend to represent them as a doctor authorized to practice medicine, surgery, or osteopathy."

6. **Optometrist:** An optometrist practicing in Wisconsin is *not* entitled to use the word "doctor," the title of "Doctor of Optometry," or the initials "O. D." in the course of his practice. Chapter 153 of the Wisconsin Statutes deals with optometry. It is completely silent on his right to use the title or any variation of it. Authority must, therefore, be sought outside that chapter. In *Nickell v. State* (1931) 205 Wis. 614, at pages 617–618, the Supreme Court held that the examination of human eyes by various mechanical means constituted "treating the sick" under the Wisconsin Statutes. That decision has not been modified by subsequent opinions of the Supreme Court, or by later legislation. The essence of the practice of optometry is the examination of human eyes by such mechanical means. Therefore, the use of the title is controlled by and forbidden under Sec. 147.14 (3), Wisconsin Statutes, quoted in Section 1. of this article.

7. **Doctor of Philosophy:** There is no Wisconsin court decision on the right of a doctor of philosophy to make public use of his title when treating the sick. It is clearly controlled and prohibited by the provisions of Sec. 147.14 (3) quoted in Section 1. of this article.

As the Rosenberry opinion stated so appropriately as to the use of the title "doctor" by chiropractors in the *Michaels* case, cited in Section 5. of this article, at page 580 of that decision:

"The title does not aid him in the treatment, it merely aids him in securing the confidence of prospective patients and in inducing people to apply for treatment."

In the somewhat earlier case of *Corsten v. Industrial Commission* (1932), 207 Wis. 147, the court concluded its discussion of the meaning of Sec. 147.14 (3), quoted earlier, with the following sentence which appears at page 149 of the decision:

"Thus these names and letters may be applied only to those who are licensed as physicians to practice medicine and surgery, and conversely those to whom the names and letters may not be applied are not physicians."

Blood Transfusions—Medicolegal Responsibilities

ALTHOUGH the blood transfusion is now generally considered to be a relatively minor procedure, it is nevertheless responsible for a significant number of medical accidents each year throughout the United States. The technique has become so routine that many physicians have a tendency to disregard the inherent dangers that accompany blood and plasma transfusions but that are not usually present in other intravenous procedures. It has been estimated that the mortality due to blood transfusions is about one death in 1,000 to 3,000 transfusions. It has also been estimated that as many as 3,500,000 transfusions are given each year in the United States. As a cause of death, the blood transfusion ranks with appendicitis or anesthesia. Yet, despite these facts, blood transfusions have been given by some physicians merely to facilitate the more rapid recuperation of a "run-down" patient, without even the suggestion of an emergency. Inasmuch as the transfusion of blood is associated with significant medical and legal hazards, such treatment should be prescribed only in instances in which it is essential for the patient's recovery.

It would seem to go without saying that accuracy in blood grouping and cross-matching tests is fundamental to a safe blood transfusion. In giving a blood transfusion, the physician, of necessity, must frequently rely entirely upon the laboratory. If blood is incorrectly grouped or cross-matched by the laboratory the physician has no way of correcting the mistake. Therefore, the utmost care must be taken to provide precautionary measures in the laboratory that will minimize the possibility of errors. Those in charge of such laboratories should entrust grouping and cross-matching tests only to reliable and specially trained technicians. Many of the accidents that have occurred are directly attributable to untrained interns and physicians who performed these tests at night or on holidays, in the absence of regularly assigned technicians.

Even when grouping and cross-matching tests are performed by highly skilled persons, labels are sometimes switched or bottles of blood mislabeled. A transfusion accident is practically inevitable once a bottle of blood has been mislabeled. Accidents occurring because of mislabeling seem to be just as prevalent as those resulting from errors in blood grouping or cross-matching. Besides errors in blood grouping, accidents occur because of clerical errors or sheer carelessness, as in the case in which one of two patients with similar or identical names may require a transfusion and blood is administered to the wrong person. If a patient suffers a prolonged illness or dies as a result of a transfusion of blood of an incorrect group, the patient, or his family, if he does not survive, may be entitled to damages unless the immediate need for blood to sustain life allowed no time for adequate tests. The transfusion of blood of an incompatible group is prima facie evidence of negligence and legal liability.

Undoubtedly, transfusion of blood of an incorrect blood group occurs far more frequently than is recorded in the published, reported court decisions, since, generally, only the decisions of appellate courts are reported. Then, too, not all the accidents that occur mature into claims; most claims are settled out of court and those that go to trial are appealed infrequently. However, the number of court decisions that have been reported, particularly within the last five years, offers convincing evidence that blood-transfusion accidents are not isolated occurrences.

A number of medical, social, and legal conclusions can be drawn from a study of the recent cases involving blood transfusions and the taking of blood —all of which are interrelated and interdependent.

From a medical standpoint, the taking and transfusion of blood have evolved from difficult to relatively simple techniques, while at the same time the number of accidents has apparently increased appreciably. This is characteristic of medical progress, for as the number of lifesaving procedures increase the number of accidents likewise tend to increase even though the ratio of accidents to treatment may remain constant or even diminish.

The compensation of injured persons at the expense of those who are deemed responsible is determined fundamentally by the social philosophy of the courts and justified by legal doctrines. Most lawyers will acknowledge the pliability of the law applicable to personal injuries and the manner in which the courts use legal doctrines to accommodate their conceptions of social justice. More and more it is evident that the courts are relying upon recognition of an underlying principle of risk distribution, and this is reflected in the frequency of verdicts for the plaintiff.

No hospital, even if it is a charitable hospital that is operated in a jurisdiction that holds such institutions to be immune from tort liability, can afford to be without insurance coverage in the face of ever-broadening liability.

When effective ways are discovered to eliminate the legal problems that arise out of accidents in blood transfusion and similar accidents, it will be physicians and not lawyers who will lead the way by devising fool-proof techniques that will avoid such errors as mistakes in blood-grouping or label-switching. In some of the grey areas the use of good medicolegal forms will offer a measure of protection. However, in the final analysis these legal problems can be dealt with adequately only if medicine will provide similar emphasis upon accident prevention and the utilization of already acquired knowledge as it does to scientific advancement, for true medical progress can only be measured by the preservation of life.—*Reprinted, in part, from J.A.M.A. Vol. 163, No. 4, January 26, 1957.*

Nine Questions about Your Professional Liability Insurance

OF COURSE, you have a professional liability insurance policy to protect yourself, your property, and your future against the hazards of malpractice claims. But, are you as well insured as you want to be, or even think you are?

Your malpractice policy does not cover all risks, and there is no good reason why it should. If it did, you undoubtedly would be paying premiums for coverage you don't need.

The important thing is for you to insure against the risks you are exposed to in your particular practice. It will be worth your while to examine your present policy with that thought in mind, and periodically to re-examine it with an eye to keeping it in line with your practice as it develops.

The following nine questions and accompanying comments will make it easier to conduct the examination. They all deal with *your* policy, and one or two of them may suggest a need for further attention.

1. Will your company be strong financially for the next twenty-five years or more?

Your malpractice policy is no better than the company that stands behind it at the time a claim becomes collectible. The adult you treat today may wait for three years (under the present Wisconsin statute of limitations) to start a lawsuit alleging malpractice in today's treatment. The infant you deliver today may start his action as late as the day before his twenty-second birthday.

It isn't the policy you hold on the day of suit or of judgment that will protect you on what you do today. You must rely *then* on the company that insures you *now*, and if, by *then*, it lacks the money to cover a claim, you do not have *now* the full measure of insurance your policy describes.

That a financial forecast covering a quarter of a century can not be very reliable goes without saying, but it also goes without saying that the place to begin in evaluating your professional liability policy is with the prospects of your insurance company for long-term solvency.

2. Are your policy limits high enough?

You can never be sure of striking the ideal balance between premium economy and adequate policy limits, but it is more comfortable and less costly to have more insurance than you need than to need more than you have.

Your professional liability policy provides two kinds of coverage. The company agrees to pay, up to policy limits, the amount of damages you may become liable for as a result of malpractice. The company also agrees to defend you against suits for such damages.

The first of these coverages has the effect of protecting your property against loss to the successful malpractice claimant. For this reason, the more prosperous you are and the better your prospects for future prosperity, the stronger are your motives for carrying high policy limits. In particular, you will keep in mind that today's limits protect tomorrow's estate.

The second coverage, which gives the company the financial burden of conducting your defense against the malpractice claimant, may help you vindicate, and thus protect, your professional reputation. A verdict in your favor can do much to restore the confidence in your skill and judgment that the news of a suit against you may undermine.

Policy limits have no direct bearing on the second coverage, since the cost of a vigorous defense is not applied toward the exhaustion of those limits. But, they do have an indirect bearing in some cases, as the following examples will show.

First, take the case of a $5,000 claim which the company considers entirely without merit. The company will conduct as vigorous a defense under a $10,000 policy as under one for $100,000. It is the company's $5,000 that will be saved by defeating the claim.

But now take the case of a $25,000 claim, a $10,000 policy, and a defense that your company appraises as uncertain. The company may welcome the opportunity to spare itself the cost of litigation by paying out its full $10,000 liability. Had the policy limits been $25,000, the company may still have preferred to settle the claim for $10,000 to $15,000, but if the claimant rejected such offers, the company might then decide to gamble on the uncertain defense rather than pay the $25,000 without a fight. If the defense actually prevails, the company will save its money and, incidentally, may also save your professional reputation. This incidental effect is the important one for you, but the risk of litigation to achieve it would be yours if low policy limits protected the company's purse, instead of yours,

against payment of an exorbitant, but doubtful, claim.

3. Does your policy permit you, without penalty, to veto claim settlements which seem expedient to the company but not to you?

Some professional liability policies permit the company to decide between litigation or compromise of a claim. Most policies, however, permit the physician to participate in this decision, by reserving the right of settlement to the company "with the written consent of the insured." Such policies, in effect, give the physician the power to veto settlement when he believes defense is in order.

You should examine your policy to determine whether you have any control over the settling of claims, and if so, whether your exercise of that control may result in a forfeiture of some part of your insurance. For example, one policy permits the physician to veto a settlement offer recommended by the company, but automatically limits the insurance coverage to the amount of the offer if the physician vetoes it.

How important such provisions are in your policy depends on the relative importance you attach to its two kinds of coverage. If you only want the company to protect your property by paying claims, you will be willing to have the company settle any claim as it pleases within the limits of the policy. But, if you are also interested in having the company defend your professional reputation against the assaults of the malpractice claimant, a policy that denies you a voice on the subject of compromise will not be entirely to your liking. Nor will you be much better pleased with a policy that, in effect, reduces its limits to something less than you bought if you presume to reject a compromise.

Of course, even if your policy does give you an unrestricted veto on settlements recommended by your company, you will exercise it with restraint, weighing carefully the company's views, and considering the greater damage to your professional reputation if you lose at trial.

4. Does your policy protect you for all the specific procedures and forms of treatment you employ in your practice?

Nearly all malpractice insurance policies start out with an insuring clause expansively stating the company's promise to pay on the insured's behalf all sums he may become legally obligated to pay as damages because of injury arising out of malpractice, error or mistake in rendering or failing to render professional services in the practice of the insured's profession. Typically, the expansiveness of this promise is then reduced by restrictive provisions appearing elsewhere in the policy.

The policy "exclusions" are the most obvious provisions to check for restrictions that may remove important phases of your professional practice from coverage.

A long list of exclusions should increase rather than decrease your faith in the policy you hold. It may be a sign that your company is not wasting your premium dollars by paying claims in risk areas where you have no exposure.

What you want to determine is whether anything listed as an exclusion constitutes a risk on which you do have an exposure. For example, if cosmetic plastic surgery is included in your practice, and your policy excludes it from coverage, you can probably buy, for an additional premium, a policy endorsement removing the exclusion. If your company won't sell you such an endorsement, you will want to investigate the possibility of a new policy without such a restriction. The same approach is indicated for any specific procedure, set of procedures, or form of treatment that your practice includes but your policy excludes.

5. Does your policy protect you against claims based on defects in any apparatus you use?

You will want to check your equipment and apparatus as well as your procedures and forms of treatment against your policy exclusions. Again, you will buy additional or new insurance if you find a gap in coverage.

6. Does your policy protect you for your acts which, though outside the immediate scope of your practice, are within the general area of your professional competence and activity?

Perhaps your competence as a physician has led you into one or more areas of activity apart from your professional practice. Perhaps you could cause an injury and become liable for damages as a result of such activity. The question is whether your professional liability policy covers the risk.

If, for example, you are the proprietor or other official of a hospital, and your policy specifically excludes coverage for any liability you may incur in such a capacity, the question is easy to answer and your course of action is clear. You will want an endorsement to your policy, or a new policy, specifically covering the excluded risk. Or you will want to make sure that the hospital has a satisfactory liability policy, one that covers not only the hospital's liability for your acts, but also your own liability for them. Don't be satisfied with a policy for the hospital if the insurance company might sue to recover from you what it pays out to discharge the hospital's liability for your acts. That arrangement would give you no protection.

But, suppose you engage in an activity other than professional practice, and your professional liability policy makes no mention of that activity. The question of coverage in that case is not so easy to

answer, and instead of guessing, the safe thing for you to do is to give your company written notice describing the activity and requesting a commitment to cover its risk. If the company will not commit itself, you will take the same precautionary measure as if your policy had contained a specific exclusion on the matter. You will enter the market for the adequate insurance you need.

7. Does your policy let the company decide the question of coverage when a claim accuses you of misconduct which, if proved, would not only establish the claimant's case against you but also relieve the company of its liability for you?

Your professional liability policy probably excludes coverage for injuries arising from criminal acts or from the acts of any person under the influence of an intoxicant or narcotic. With or without a formal exclusion, it will not cover for liability you may assume under an agreement guaranteeing the result of any treatment. Failure to deliver on such a guarantee is breach of contract and not malpractice; it is not within the scope of malpractice insurance.

You will be pleased to know that these things are not covered, and that your premiums are not being used to underwrite quackery, gross negligence or crime.

But, what if a patient falsely charges that you injured him in the course of treatment and were intoxicated or engaged in a criminal act at the time? Though, under the policy exclusions, you would not expect your insurance company to assume any liability on your behalf for damages, the question is whether the company will disclaim all responsibility for the conduct of your defense. If the patient's charge were true, there would be no coverage whatsoever. But if, prior to verdict, the company denied coverage for defense in the suit, the denial would amount to a presumption of your guilt pending proof of your innocence.

Your policy may or may not contain clear cut language defining the company's options in ambiguous situations of this kind. For example, it may permit the company to decide the question of suit coverage unilaterally; or it may contain an outright denial of coverage for defense when the claim asserts conduct falling within any exclusion. On the other hand, it may leave the question of defense coverage open until the basis for the exclusion has been definitely established. Probably no policy is wholly satisfactory on this point.

Perhaps the most important thing to keep in mind about a case presenting the question not only of liability to the claimant, but also of coverage by your insurer, is that you should have independent legal counsel of your own and should not rely entirely on your insurance company. In a case of this kind, your interests and the company's may be in serious conflict.

8. Does your policy protect you against claims based on the acts of other persons?

Not only your own acts, but also the acts of any employees or partners you have, may give rise to malpractice claims against you. You will want to make sure that your professional liability policy protects you no matter who commits the act.

Most policies specifically state that the coverage protects the person insured for malpractice, error or mistake in rendering or failing to render professional services in the practice of the insured's profession described in the declarations, committed during the policy period of the insured "by any person for whose acts or omissions the insured is legally responsible except as a member of a partnership." The first thirteen of the above quoted words automatically take care of your liability for the acts of your employees. The same thirteen words would also take care of your liability for the acts of your partner if it were not for the exception expressed by the concluding seven words.

For additional premium, your company will doubtlessly issue an endorsement to your policy insuring you for the act of any partner to the extent that he himself fails to satisfy a malpractice claim for which he is directly liable, subject, of course, to the limits of your own policy.

If you have employees, you should check your policy for language substantially like that already quoted. If you have one or more partners, either you should be absolutely certain that each one keeps himself insured to limits as high as those you deem prudent for yourself, or else you should invest in insurance for yourself against your liability for his acts.

9. Are the "declarations" in your policy correct?

Some of the earlier questions and comments in this article may have brought home the fact that your own professional liability insurance needs may differ from those of other physicians. Their risks may be greater or less than yours, and so also the premium charges made for the insurance you and they may carry.

In fact, it is quite possible for two physicians to have policies with the same company containing the same standard provisions and special endorsements, and still differ with respect to the actual insurance each has and the premium each pays. The reason is that the policy "declarations" may differ for the two men.

The declarations in your policy not only state your name, the fact that you are a physician, and the cash limits of the company's liability, but also may contain some detail about the manner in which you practice. To the extent that it does, it describes

the risk that your company agrees to insure. If there is a discrepancy between the facts and what the "declarations" state, you may find to your regret when a claim arises that the company's agreement does not cover your situation. Your insurance may be void.

Obviously then, you should have any errors you find in the declarations corrected immediately. Moreover, you should have the declarations revised to the extent necessary as often as your practice undergoes any change. Care in these matters provides insurance against loss of insurance.

PREPRINTED PRESCRIPTION BLANKS

The Narcotics Bureau of the Internal Revenue Service reports that neither Federal law nor administrative regulation prohibits the printing of the physician's narcotic registration number on prescription blanks. However, the Narcotic Bureau prefers that physicians have their prescription blanks printed without including the narcotic registry number. According to the Bureau, if the physician follows the practice of writing in his registry number at the time narcotic prescriptions are issued, it will facilitate the easier detection of forged precriptions.

PREPARATION OF MANUSCRIPTS FOR WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

Correspondence: Address all correspondence relating to publication of scientific papers to the Medical Editor.

Manuscript: Type double spaced, on 20 pound white paper, 8½ by 11, with one-inch margins at the top, bottom, and right, and 1½ inches on the left. Submit the original and two carbon copies. Use the metric system throughout. Call drugs by their generic names. The trade names can be added, in parenthesis, if they are considered important. Keep one copy of the paper.

Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

Footnotes and References: Use the style of the *Index Medicus* published monthly by the National Library of Medicine, which requires, in the order given: name of author, title of article, name of periodical, with volume, pages, month—day of month if weekly—and year as follows:

4. Doe, J. E.: What I Know About It,
Wisconsin Med. J. 54:717–719 (Dec.) 1954.

And, include only those references specifically referred to in the text. References will not be published with the article, but will be available upon request to the Journal.

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Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

When Malpractice Threatens

Should You Fight or Settle?

HERE'S A HELPFUL FORMULA FOR HANDLING A DELICATE SITUATION

LET'S face it—there is no guarantee against a malpractice suit. Sooner or later, you'll almost certainly be faced with a claim, justified or not. How you react may save your reputation, protect your pocketbook, and stave off a flood of nuisance suits.

Each case is different, but here are some fundamentals that every doctor should know:

1. Keep your eyes open

Watch your patient's emotional and psychological reactions. Be alert to dissatisfaction, grumbling, and uneasiness of the patient or his family. Keep an ear cocked for rumors from outside. Early recognition may give you time to repair strained relations.

2. Don't panic-just listen

Your real test will come when the complaint or accusation is made. There's a strong temptation to defend yourself, argue, alibi, explain, or even retaliate. If you remember nothing else, remember this: Don't do it. Just listen carefully and patiently and be thankful you're getting that much advance notice.

3. Speak with extreme caution

Anything you say may be held against you. Not long ago a patient threatened a Wisconsin physician with malpractice when her "sprained knee" turned into a long-term disability. Confronted in his office by the patient, the doctor did a quick recheck of the situation and replied, in effect, "You're right. If I'd taken a couple of follow-up x-rays three months ago, we would have caught it." This admission was "manna from heaven" to the patient. Whether or not the doctor's treatment had been good medical practice, his impromptu remark forfeited any defense he might have had. The case was settled out of court.

The case of the sprained knee is a good example of what lawyers call "the doctrine of *res ipsa loquitur*," that is, the thing speaks for itself. Technically, *res ipsa loquitur* is held to apply whenever one person is injured by an instrumentality entirely in the control of another person, the use of which does not ordinarily result in injury if the person in control exercises due care.

In the field of malpractice, the doctrine of *res ipsa loquitur* has been applied chiefly to cases which involve slipping instruments; sponges left in the tissues; burns from heating modalities; roentgen radiation injuries, generally limited to cases in which the roentgen ray is being used in diagnosis; infection through the use of an unsterilized needle or instrument; or injury to a portion of an anesthetized patient's body outside the field of treatment or operation.

Similarly, a single careless statement or admission might create liability for damages where no liability exists. What is more, an admission on the part of the defendant may free the plaintiff from the necessity of offering medical expert testimony to prove the alleged malpractice. The doctrine of *res ipsa loquitur* infers negligence on the part of the defendant. Its application forces the defendant to explain away the inference if he can.

4. Be quick to notify your insurance carrier

As soon as you suspect a malpractice suit in the making, notify your malpractice insurance carrier immediately and get private legal counsel. Don't wait. Any delay may be disastrous to the preparation of a defense. Adequate defense in the unjust malpractice case is a difficult task. No doubt poor defense has lost many a case. Physicians with little or no knowledge of the law are obviously out of place in attempting to defend themselves. Lawyers with little or no medical knowledge or experience in malpractice cases are not a good bet. In the face of a suit, you will be wise to find the best available expert advice.

5. Be slow to compromise

Don't be too quick to settle. Many doctors operate on the theory that a small settlement will be less expensive than the cost, publicity, loss of time, and mental and emotional strain involved in the defense.

Experience shows that unjust and absurd malpractice claims double and triple in areas where doctors are found to be a "soft touch." The increased number of malpractice claims and the higher insurance rates are a direct result of the "settle-it-quick" attitude on the part of many doctors. For your sake and that of your colleagues, you should make a determined opposition to any unjustified claims.

6. Collect your defenses

At the slightest possibility of a claim, begin to pull together your records, reports, and other evidence which might be required for your defense. At this point, every shred of recorded evidence becomes mighty important. But in no case should you alter your existing records in any way.

7. Settle a meritorious claim out of court

The doctor who is actually guilty of malpractice is not likely and probably should not be allowed to go free of penalty. Let your conscience, not alone your pride, be your guide. Meritorious claims should be settled out of court—preferably before a suit has been filed. But never settle without having competent legal advice.

POISON INFORMATION CENTERS

MADISON • Phone AL 6–6811

Call University Hospitals, ALpine 6–6811, and ask for "Poison Center" for information concerning any substance suspected of being poisonous.

MILWAUKEE • Phone DI 4–7100

The Poison Information Center in Milwaukee was established in 1956 through the efforts of The Medical Society of Milwaukee County Subcommittee on Accident Prevention. It is located in Milwaukee Children's Hospital.

EAU CLAIRE * Phone TE 2–6611

The Poison Information Center for physicians in the Eau Claire area is located at Luther Hospital.

GREEN BAY * Phone HE 5–5311

For physicians in the Green Bay area, the Poison Information Center is located at Bellin Memorial Hospital.

KENOSHA • Phone OL 4–5311

The Poison Information Center for physicians in the Kenosha area is located at Kenosha Hospital.

The Poison Information Centers maintain complete information on poisons by commercial name, ingredients, relative toxicity and treatment procedures. Their files are kept current through periodic releases received from the Clearing House for Poison Control Centers in Washington, D.C.

What is Your Best Defense Against

MALPRACTICE?

HERE ARE 25 CHECK POINTS

RECENTLY, at a county medical society meeting, an indignant physician growled: "When is the State Medical Society going to do something about malpractice insurance?" He had just received his premium notice. It was $30 higher than the year before—and triple "what I paid 10 years ago."

A front-page headline in the local paper the same day declared: "Doctor Sued . . . Claim Wrong Medicine Given."

The intensity of the doctor's complaint is in direct proportion to the frequency of the headline—increased rates result mainly from more and higher suits. County, state, and national medical associations seem to be between the devil and the deep blue sea. Doctors plead for a state-wide group malpractice program. Some states have tried it; haven't been happy with the results. Here and there, a plan works—for a while. The American Medical Association has spent several years studying the problem. It has not recommended a nationwide AMA-sponsored plan.

What's going on to create this furor about malpractice? Answers and ideas are a dime a dozen but the situation boils down to this:

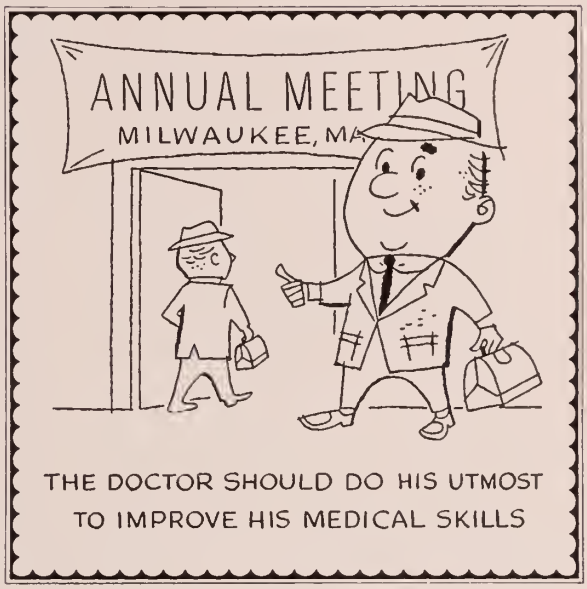
The incidence of malpractice claims is 15 times greater today than it was ten years ago. Malpractice suits are contagious. Right or wrong, each malpractice suit breaks down further the public's confidence in the medical profession, leading to even more suits. Lower rates for malpractice insurance will be hard to come by.

In the final analysis, the doctor's best defense against malpractice and rising insurance rates is prevention.

Here are a few fundamentals to understand and remember:

*Any patient may bring a malpractice action against any physician who has attended him professionally. Most malpractice suits are without merit, but the damage is done with the first accusation.

*Know the legal interpretation of malpractice. The law requires that in diagnosing or treating a patient, you must possess the skill and exercise the care commonly possessed and exercised by other reputable physicians in the locality. If you call yourself a specialist, you must meet the standards of practice of a specialist in your field. These things are true even if you render your services without charge.



*The standard of practice is always determined by what other reputable physicians in the community, or in similar communities, would or would not do in the care of similar cases. Because medicine is not an exact science, not all patients who receive medical treatment get well. Considering each patient as an individual, there are few if any conditions for which there is a specific, single, universally recognized remedy or procedure. There is often room for honest difference of opinion. A mistake in diagnosis or an error in judgment may be recognizable only as a matter of hindsight. In the exercise of your best judgment, you may use medicines or methods of treatment different from those of some of your colleagues; and you may get different results. However, the mere fact that a patient is not cured or does not

progress favorably does not suggest culpable ignorance or negligence on your part. The main point to keep in mind is to exercise the ordinary skill and care required in the treatment of your patient. A malpractice charge is justifiable only if you have not done something you should have done or have done something you should not have done in terms of accepted standards of practice.

*The personal relationship between the physician and patient often determines whether or not an action is brought. Patients who have had a frank and full understanding of their ailments and treatment and who believe that everything possible has been done for them are not so likely to sue for malpractice—even though the results may have been death, unusual and unexpected physical change, or disability or continuing complications. According to surveys by several state medical societies and the American Medical Association, malpractice suits more often arise when the patient believes he has not been carefully attended; when he is resentful of some words or deeds of the physician, and others who attended him; or when some third person, either physician or nonmedical person, raises some doubt in his mind as to the propriety of the treatment. Emotional and psychological factors are obvious danger points to the physician-patient relationship. In these days of widely publicized "miracle cures," patients are likely to expect more dramatic and highly successful results than might be expected in the average case. The treatment of burns and fractures, tonsillitis, and appendicitis is generally regarded by the public as so routine and simple that any undesirable results are regarded as the basis for malpractice. Despite serious injury, a patient is likely to expect modern science to restore full motion to battered limbs or beauty to previously unblemished surface tissues. In physician-patient relationships, first impressions are the strongest. That's why it's so important for the physician to do everything in his power to develop an honest, frank, and psychologically sound relationship with his patient from the very first contact.

It is unfortunate that a physician cannot be satisfied with merely practicing good medicine. Knowing his legal duty to his patient, he must fulfill it and, at the same time, act in such a way as to anticipate an unjustified claim of malpractice in every act of treatment.

Here are 25 check points in malpractice prophylaxis. They will help the physician avoid legitimate malpractice, prevent the filing of unjustified claims, and protect him in the event of an unjust claim:

1. **The physician should be meticulous in providing every patient with care that meets the requirements of good medical practice.** He must possess the degree of skill possessed by other reputable practitioners in the same field of practice. He should do his utmost to maintain and improve those skills through postgraduate medical education. He must, in addition, exercise the degree of care, diligence, and judgment commonly and ordinarily exercised by other reputable members of his profession in similar circumstances.

2. **Avoid any criticism of the work of other physicians before the patient.** At least 65% of all suits are said to originate in criticism to the patient about treatment by another physician.

3. **Criticism of one physician by another is legitimate only when full facts are gathered from all parties.** At that point the discussion should take place privately between these physicians or within recognized legal or medical bodies. Use discretion in speaking to nurses, interns, or residents concerning the nature of the disease in the course of treatment. Unexplained casual remarks may produce fear or suspicion.

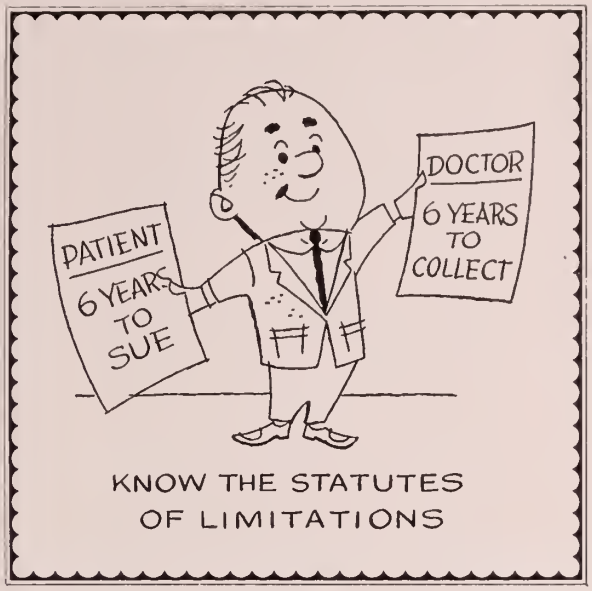
4. **Maintain adequate medical records on every case.** A good case record should include a medical history, a report on physical examination of the patient, and copies of all reports of laboratory work done. These data generally serve as the basis for a working diagnosis. If the diagnosis is not possible, consultation is desirable. Consultation reports must be in writing. Thereafter, a good record will include progress notes to pro-

vide a continued history of the case, its complications and sequelae; instructions to the patient; and the prescriptions given. The record should indicate what was done and when it was done. It should clearly indicate that nothing was neglected and that care was given to meet the standards demanded by the law. Copies of any special forms and of reports used or made in a particular case are also a part of a good record. All records should be maintained by the physician as if he were anticipating the likelihood of offering them in court at a later date. If a patient discontinues treatment before he should or fails to follow the physician's instructions, the record should show it. A good method is to file a carbon copy of the letter sent to the patient advising him against the unwise course he is choosing.

5. **Avoid making any premature statement which might be construed as an admission of fault on your part.** A single careless statement might create liability for damages where actually no liability exists. Even though good practice may have been followed throughout the course of treatment, offhand remarks may be made under emotional stress to the partner, assistant, office nurse, patient, or his friends. The effect of such a remark when reported to a jury is incalculable and almost impossible to counteract. Further, an admission on the part of the defendant may free the plaintiff from the necessity of offering medical expert testimony. Similar admissions might be made by an agent or an employee of the physician during the course of treatment and within the scope of the employment. It is important to instruct employees to make no such statements at any time.

6. **Use large and frequent doses of tact.** You should maintain a proper professional manner and sound attitude toward both the patient and the patient's family at all times. Tact is most important in the discussion of fees. It is invaluable in avoiding over-optimistic prognoses, and especially any promise that would seem to be a guarantee of a particular result. Most of all, tact is essential to avoid the betrayal of privileged communications.

7. **Do not hesitate to use consultation.** You must be especially alert to sense early dissatisfaction and disturbing emotional undercurrents. If the patient is not doing well, consultation may be suggested. If the patient is dissatisfied or complaining or if the family's attitude indicates dissatisfaction, consultation should be demanded. If consultation is suggested by the family or the patient, you should accept it promptly and graciously. The use of a consultant may give you your best protection against a malpractice claim.



8. **Do not be hesitant to discuss fees and arrive at an understanding.** Grievance committees throughout the nation report misunderstanding on fees as the most frequent cause of complaint. No doubt fee problems trigger a high proportion of malpractice claims.

9. **Think twice before using pressure to collect fees.** A good physician is also a good businessman, but his attitude in collection must always be more professional than commercial. Be wise and cautious in your methods of collecting fees. The patient who is slow to pay his bills might be unusually quick to respond to suit by a counterclaim based on a groundless charge of malpractice. Therefore, the physician will do well to wait for three years before commencing an action for his fees. Although the patient may still argue that the treatment was so far below professional standards as to be noncompensable, at least he will be barred from basing a malpractice claim on the treatment given.

10. **Know the statutes of limitation.** In Wisconsin, the patient, in order to claim damages against his physician for malpractice must bring suit within three years of the alleged event. The same rule applies in those situations where the patient is sued by the physician and where, were it not for the statute of limitation, the patient might assert malpractice as ground for a counter-

claim for damages against the physician. Ordinarily, a suit for unpaid salary, wages, or other compensation for personal services must be brought within two years; but fees for professional services are not so limited. Instead the physician has six years in which to bring suit for fees. In any event, keep these statutes in mind before you press for payment of fees.

11. **Do not neglect or abandon your patient.** You are not legally obligated to accept the care of any patient. But once you assume that responsibility, you must see that the patient has the care and treatment required by his condition until the time you are discharged or withdraw from the case. If you decide to withdraw from a case, you are legally bound to give the patient reasonable notice of your intention and allow him the opportunity to replace you.

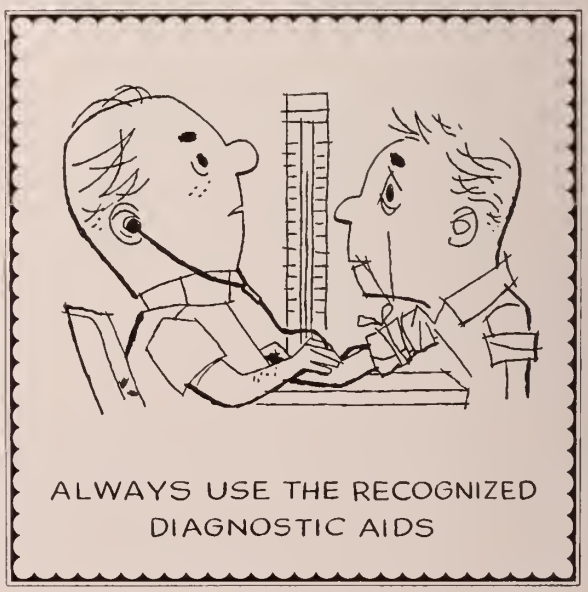
12. **You may, by the use of a notice or special contract, limit the services you agree to render.** For example, you may agree to treat the patient only at a certain place or for a limited time or for certain conditions. Conversely, your obligation increases if you make an express agreement or promise that you will effect a particular result. In other words, you must fulfill the terms of any special contract you might make. Remember, also, that the mere act of accepting a patient does not insure results, unless you commit yourself by specific promise.

    Once you have accepted the care of a patient, you must proceed diligently and without unnecessary delay. If for some reason you will be unavailable to your patient for care that he might reasonably require, you must make adequate provision and issue proper instructions (consistent with the standard of practice) for the care of the patient in your absence. You should advise your patient of any intended absence from practice and should recommend or make available a qualified substitute. You must also issue proper instructions for the protection of those coming in contact with the patient, such as family members, relatives, and nurses' aides.

13. **Limit your practice according to your qualifications.** Let your qualifications be your guide in selecting patients. Self-assurance is desirable, if not vital; but overconfidence and arrogance are dangerous. The ready use of consultation or assistance is substantial protection against malpractice.

14. **You must find or anticipate any condition reasonably determinable or reasonably likely to develop.** This means you must give your patient sufficient attention to give you the opportunity to know his true condition. You should always utilize recognized diagnostic aids as indicated by the condition—blood count, Wassermann, pregnancy test, culture, smear, urinalysis, stool examination, or x-ray (original or follow-up). You should take every precaution to make a complete diagnosis and to discover a reasonably determinable condition. Do your utmost to utilize an indicated prophylactic measure (antitoxin, for example), give instructions as needed, follow up the original treatment or operation, and institute measures to protect contacts. A common allegation in malpractice action is failure to use the x-ray at all or failure to make sufficient use of the x-ray. Whenever a fracture which was not diagnosed is present and no x-rays were taken, the conduct of the attending physician is likely to be condemned as not coming within the standards of good practice. Whenever a bad result, deformity, or limitation of motion occurs, your defense is immeasurably strengthened by the possession of a series of x-rays taken at intervals during the progress of the case. Should your patient refuse to have an x-ray made, you should immediately fortify yourself with the strongest written evidence. X-ray records, as well as the entire case record, should be carefully preserved beyond the time during which a malpractice suit may be brought.

15. **Remember: you are liable for the acts of others.** A physician may reasonably delegate



responsibilities not requiring professional judgment, but he should do so with great care and should carefully supervise his assistants and employees. There are many instances in which you may be responsible for the negligent acts and omissions of others as well as your own. For example, you are responsible for the acts of your assistants and employees, for any negligence on their part occurring during the course of their employment. If you practice with another physician as your partner, each partner is liable not only for his own acts and those of his partner but for the negligent acts of any agent or employee of the partnership.

When two independent practitioners are caring for a patient, each is liable not only for his own acts but for doing nothing about the negligence of the other which he has observed or, which in the exercise of ordinary diligence, he should have observed. As the attending physician, you are not generally liable for the negligence of an intern, a nurse, or other hospital employee. You are, however, responsible for the acts of the hospital personnel in so far as they are carried out under your immediate supervision and control. Thus, the operating surgeon, and not the hospital, is held liable for any negligence of operating room attendants during the performance of surgery.

16. **Keep the professional secret.** There are strong legal and ethical reasons why you should keep inviolate all confidential communications between you and the patient.

This was explained in greater detail in an article, "Taking the Wraps off the Professional Secret," which appeared in the January, 1959, issue of the *Wisconsin Medical Journal.*

17. **It is extremely hazardous to sterilize any patient except when a positive medical indication exists.** There should be no promise or guarantee that the patient will be sterilized as the result of the procedure undertaken. If sterility is a likelihood or possibility as a result of contemplated surgery, you should explain that probability and obtain a signed authorization from both spouses.

18. **Do not examine a female patient unless a third person is present.** The only exception is an actual emergency. There is no more serious or destructive charge than that of undue familiarity. The only way to avoid claims of this sort seems to be to have someone else present during all such examinations.

19. **Don't experiment.** In the treatment of the patient, the physician must not experiment. In all diagnosis and treatment, he must follow good practice and common practice.

20. **Confirm prescriptions in writing.** Written prescriptions are advisable. Because of the increased possibility of error in transmission by telephone, it is always advisable to confirm such prescriptions in writing.

21. **Check your equipment.** Make a frequent check of the condition of your equipment and utilize all available safety installations. X-ray machines, diathermy equipment, and

Patient fails to carry out advice

Mr. Robert Jones
Midville, Wis.

Midville, Wis.
Jan. 1, 1957

Dear Mr. Jones:

At the time of my examination of your ankle this afternoon, I advised you of the desirability of having x-rays made. This you refused to do.

Upon your insistence that I treat your ankle and foot, without benefit of x-rays, I agreed to do my best in the circumstances, but as I advised you this afternoon, and must repeat now, I cannot establish, without x-rays, whether or not you have incurred a fracture.

In your own interest, I urge that you have an immediate x-ray study made of your foot and ankle.

Yours very truly,

John Brown, M.D.

Substance of letter to patient to be changed to fit the particular facts and circumstances. Carbon copy, with proof of mailing of original written thereon, to be filed with medical case record.

Patient fails to keep appointment

Midville, Wis.
Jan. 1, 1957

Mr. Robert Jones
Midville, Wis.

Dear Mr. Jones:

My records indicate that you failed to keep your appointment of December 31, and that you have not made any subsequent appointment or appearance in the office.

In your own interest, may I call to your attention the fact that further professional attention, is in my opinion, definitely needed. If there is some reason why you prefer not to return to this office, I urge that you immediately seek other competent professional care. I shall be glad to give the benefit of my knowledge of your case to your subsequent physician, should you elect to receive the needed attention at other hands.

John Brown, M.D.

Yours very truly,

When a patient fails to keep an appointment, or discontinue treatment before he should, it is desirable to send him a letter, incorporating the pertinent facts and the recommendations. File a carbon copy, endorsed with a certificate of mailing, with medical case record. Registered mail may be used.

Patient discharges physician from case

If a physician justifies his failure to continue in attendance upon a patient upon either his having withdrawn from the case or of having been discharged by the patient, the burden of proof of such contention is upon him—hence the desirability, if not the actual necessity, of having written evidence available.

Midville, Wis.
Jan. 1, 1957

Dear Mr. and Mrs. Jones:

This is confirmation, and my acknowledgment, of the fact that you have, as of this date, discharged me from further professional attendance upon you in your current illness.

Should you desire, I shall be glad to cooperate with the physician you now call, in supplying him with such information as I have gained in respect to your case.

Yours very truly,

John Brown, M.D.

Midville, Wis.
Jan. 1, 1957

Mr. Robert Jones
Midville, Wis.

Dear Mr. Jones:

You have repeatedly failed to follow my advise and recommendations.

I am therefore advising you of my intention to withdraw from further professional responsibility in connection with your case. To allow you a reasonable opportunity to secure another physician, I shall be available, at your request, to render you service for three days from your receipt of this letter, but not thereafter. In this period of time, in this community of several hundred physicians, you can readily fill my place.

I shall be glad to give, to any reputable physician of your choice, the benefit of such knowledge as I have gained of your case.

Yours very truly,

John Brown, M.D.

Physician withdraws from case

A physician may withdraw from attendance upon a patient, but he must give reasonable notice of his intention to do so and must allow the patient reasonable time and opportunity to fill his place. It is desirable that written evidence be available as to the withdrawal and the reasons therefor.

It is a serious question of judgment, whether, when a patient fails to cooperate or refuses to follow advice, the physician should continue on the case. It is recommended, that, if the physician decided to continue to care for an uncooperative patient, who, for example, refuses to have an indicated x-ray study made, he should demand and require consultation.

Letters should be sent and carbon copy filed. The wording should be simple and direct, but the intent and meaning must be clear and certain.

Consent to operation

Midville, Wis.

Jan. 1, 1957

1. I hereby authorize and direct Dr. _____ to perform the following operation upon me _____ and to do any other procedure that (their) (his) judgment may dictate during the above operation.

2. I understand that the surgeon (surgeons) will be occupied solely with the surgery, and that the administration and maintenance of the anesthesia are independent functions, and will be in charge of Dr. _____. I consent to the administration of such anesthetic, or anesthetics, as Dr. _____ may deem advisable in my case.

3. It has been explained to me that I may be sterile as a result of this operation, although no such result is warranted or guaranteed. I understand what the term sterility means and, in giving my consent to the operation, I have in mind the possibility (probability) of such a result.

4. I join in authorizing the performance, upon my (husband) (wife), of the surgery consented to above. It has been explained to me that, as a result of the operation, my (husband) (wife) may be sterile.

Signed _____

Witness _____

Hour _____ A.M. P.M.

** Cross out paragraphs not applicable to particular case.*

Consent to operation on a minor

Place _____

Date _____

1. I (we) being the parent(s), guardian, custodian of a minor of the age of ___, do hereby authorize and request Dr. _____ to perform such surgical operation on the person of said _____, a minor, as the judgment of said Dr. _____ may dictate.

2. I (we) also authorize and request the employment of such anesthetic or anesthetics as may be deemed suitable in the judgment of the said Dr. _____, or in the judgment of the anesthetist selected to administer the anthestic or anesthetics in this case.

Signed _____

_____

Witness _____

Hour _____ A.M. P.M.

A similar consent form may, and should, be used in the case of a patient who is incompetent; signed by guardian, custodian, or other person legally responsible for the incompetent.

similar devices utilizing electrical or chemical processes should be most closely watched.

22. **Be sure to get written consent for operations.** Any adult in a clear state of mind may authorize operation upon himself. Oral consent might be considered sufficient; but because of the difficulty in proving that it was given, physicians should invariably request a witnessed consent in writing. If the patient is a minor (under the age of 21), consent is to be obtained from the parent or guardian. If the individual is mentally incompetent, the consent of the one who stands in the position of guardian is required. When an operation is made compulsory by law (such as vaccination or sterilization), the law furnishes the consent. If an operation is unlawful, consent to the performance thereof does not absolve the surgeon from liability.

    In an emergency which demands immediate action for the preservation of the life or health of a patient and in which it is not practicable to obtain his consent or the consent of anyone authorized to speak for him, it is your duty to perform without consent such operation as good surgical practice demands.

    Special attention should be given to operations which might or are likely to result in sterility. The trend of cases in recent years indicates that it is extremely unwise to pursue a course of treatment that is self-hazardous or capable of producing harmful effect without securing a written statement from the patient or from someone legally responsible for the patient—a statement which clearly expresses understanding of and consent to the specific treatment.

23. **Consent is required for autopsy.** You must secure consent to perform a postmortem examination. You should most certainly have this in writing. It should be sufficiently comprehensive to allow the removal and taking away of tissue if such is to be done.

24. **What to do if called as a witness.** Always secure legal advice if you are called to attend a coroner's inquest as a witness in a case in which you have been in professional attendance. The same would hold true whenever you are called as a witness in some case in which you have been the attending physician, assistant, or consultant.

25. **Don't talk about your malpractice insurance.** You should not reveal to your patient or his family that you carry professional liability insurance. You should not (except on the recommendation of your legal advisor) write a letter or make any statement with reference to a malpractice claim. Immediately on being advised of even the possibility of a suit, you should consult with your attorney.

You can't entirely prevent a malpractice suit. You can only know your own rights and those of the patient, conduct your practice as best you know how, and continually keep up your guard against an unjust malpractice accusation.

REFERENCES

1. Regan, L. J.: Malpractice, an occupational hazard, J.A.M.A. 156:1317–1318 (Dec. 4) 1954.
2. Regan, L. J.: Malpractice and the physician, J.A.M.A. 147:54–59 (Sept. 1) 1951.
3. 48 C. J. 1131; Jackovach v. Yocum (Iowa), 237 N. W. 444.
4. Agnew v. City of Los Angeles (Cal.) 218 Pac. (2d) 66.
5. Regan, L. J.: Doctor and Patient and the Law, St. Louis, The C. V. Mosby Company, ed. 2, 1949, pp. 468–477.
6. Wisconsin Statutes, 1959, Section 330.19 (3).
7. Wisconsin Statutes, 1959, Section 330.205.
8. Wisconsin Statutes, 1959, Section 330.27.
9. Wisconsin Statutes, 1959, Section 330.21 (5).

STERILIZATION

The sterilization of individuals, for other than therapeutic reasons, is undoubtedly limited in Wisconsin to those cases specifically authorized by statute. An institutionalized criminal or mentally diseased person, under Sec. 46.12 Stats., may be sterilized provided that the elaborate precautions set forth in that statute are followed.

A physician who sterilizes a person for any but clearly therapeutic reasons may be guilty of performing an illegal operation. For that reason it is recommended that additional physicians be called in consultation to determine the therapeutic advisability of the procedure.

The illegal character of any but a therapeutic sterilization would not be altered because the patient or his representative consented in writing to the operation.

Reference: Section 46.12, Wisconsin Statutes, 1959.

The Law Gets Tough With ABORTIONISTS

Do you know how to protect yourself when called to treat an attempted abortion?

EVERY physician should know the Wisconsin law on abortions. It puts the squeeze on the abortion racket, but it lets the honest practitioner know where he stands.

Since July 1, 1956, Wisconsin's Criminal Code has permitted a fine up to $5,000 and imprisonment up to three years, or both, for the intentional destruction of the life of any unborn child. If the life destroyed is that of an unborn quick child or of the mother, the imprisonment may be as high as 15 years.

To the law, "unborn child" means a human being from the time of conception until it is born alive. Of course, any pregnant woman who intentionally destroys the life of her unborn child may be fined or imprisoned up to two years.

A therapeutic abortion, however, is exempt from these penalties, but only when three specific conditions have been met:

1. The abortion must be performed by a physician.
2. At least two other physicians must advise that the abortion is, or appears to be, necessary to save the life of the mother. Important: Therapeutic necessity must be based on danger to the mother's life, not simply on danger to her health.
3. The abortion must be performed in a licensed maternity hospital, except where emergency prevents.

Criminal abortionists will find the last condition hard on their activities. In the past, abortionists have centered their operations in private establishments or their victims' homes. When caught, they argued their services were necessary to save the mother's life. Now they have the tougher task of arguing that the mother's life was in such immediate danger that there was no time to remove her to a licensed maternity hospital.

The honest practitioner will have no difficulty with the abortion law. But watch out, doctor, when a woman asks you to treat her after an attempted or a completed abortion. Your innocent efforts to aid her may boomerang.

Frequently, an abortionist will merely start the procedure, then advise the woman to consult her own physician for all future care. Her own physician may find it hard to distinguish the criminally induced case from the case with natural causes. Most women would shy from admitting an abortion attempt. If the woman dies, suspicion can easily turn to those near at hand.

One physician called to treat a woman after an abortion refused to take charge of her unless she made a full statement concerning the abortion. He said he needed it for his own protection and to help him begin proper treatment. The woman refused the statement and later brought suit against the doctor. The Supreme Court of Wisconsin said: "It was a very proper request for him to make under the circumstances."

Here are two steps recognized by the highest court in Wisconsin as reasonable precautions before aiding a woman who has attempted or completed an abortion:

1. Insist on the presence of at least one other physician (not an associate) before treatment is given.
2. When no other physician is available, insist on a written statement from the patient, in the presence of witnesses if possible, reciting the facts concerning the performance of the abortion and including the name of the abortionist. The necessary treatment should then be given only after the patient understands that the physician may use the statement in event he later requires it for his own protection.

In every instance, of course, complete, detailed patient records should be maintained.

Abortion Deaths to be Reported

Sometimes forgotten is the statutory requirement that all physicians must immediately report knowledge of any death following an abortion. The report must be made to the sheriff, police officer, or coroner of the county in which the death occurs. Failure to report is a misdemeanor punishable by fine or imprisonment.

Legal counsel for the State Medical Society believes the reporting requirement is intended to apply only to those situations in which the mother dies following an abortion and not to the destruction of a fetus. However, the prudent physician will do well to protect himself by reporting all deaths associated with abortion.

Whenever consulted by a woman who has been treated by an abortionist, the cautious physician will attempt to obtain a complete disclosure by the patient to proper authorities. Frequently this is difficult, if not impossible, to accomplish. Sometimes a woman will attempt to conceal her condition and its cause even until death.

What can the physician do under such circumstances? Primarily his duty is to his patient. He should do the best he can for her up to the time it seems probable that she will die as the result of a criminal abortion or miscarriage. At that stage it would be advisable to call the district attorney to give him a chance to obtain a statement from the patient.

No harm can come from such a procedure. If the patient dies, the physician is bound to report the cause of death. At that time he must either disclose the fact on the death certificate or he must accept the responsibility for being an accessory after the fact by concealing the cause of death.

If the physician does not offer the district attorney a chance to get a statement from the patient and the patient later dies, the physician's reputation may be subject to suspicion. People may wonder what motive he had for failing to give the prosecuting attorney the opportunity to obtain a dying declaration.

REFERENCES

1. Wisconsin Statutes, 1959, Section 940.04.
2. Wisconsin Statutes, 1959, Section 966.20.
3. State v. Law, 150 Wisconsin 313, (1912).

TENTATIVE SCHEDULE—ORTHOPEDIC FIELD CLINICS

January 1, 1961–June 30, 1961

STATE DEPARTMENT OF PUBLIC INSTRUCTION, BUREAU FOR HANDICAPPED CHILDREN
CRIPPLED CHILDREN DIVISION, MADISON 3, WISCONSIN

LOCATION	*DATE*	*LOCATION*	*DATE*
Ashland	February 8 and 9	Sheboygan	April 26 and 27
Manitowoc	February 15 and 16	Superior	May 5 or May 19
Racine	March 8 and 9	Eau Claire	May 11 and 12
Marinette	March 15	Rhinelander	May 24 and 25
Kenosha	March 22 and 23	Chippewa Falls	June 7 and 8
Wausau	April 13	Darlington	June 14
La Crosse	April 18 and 19	Lancaster	June 15

Note: This is only a tentative list and subject to changes.

FOR: The clinics conducted by the Crippled Children Division of the Bureau of Handicapped Children are for persons under 21 years of age, who are referred by their family physician for orthopedic diagnosis and consultation. Reports of the examination are then sent to the referring physician following the clinic.

REFERRAL FORMS: Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for the individual clinics so when requesting same be sure to state approximately how many forms are needed and for which clinic or clinics. It is important that we know well in advance the number of persons desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral form will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 122 West Mifflin Street, Madison 3, Wisconsin.

Locum Tenens

For a variety of reasons a physician may have occasion to leave his practice for an extended period of time. The choice of the interim custodian of his practice and the arrangement under which he carries it on are then of very real importance.

IN THOSE cases where a locum tenens is secured, the State Medical Society urges that the arrangements be confirmed by a written contract, drawn with the assistance of a local attorney. In arriving at the terms of such an agreement members should consider these fundamental points:

Licensure

The locum tenens must be licensed in Wisconsin as one entitled to practice medicine and surgery. Membership in a local and State Society is further assurance of his ethical standing and abilities.

Staff Privileges

Association on the hospital medical staff, where necessary, should be arranged. The locum tenens should be apprised of the conditions necessary to a continuation of this association, and his compliance with them should be a continuing condition of the contract.

Malpractice Liability

Malpractice insurance should be maintained by both parties under all circumstances.

Partners, Independent Contractor, or Employe

One of the most important matters for decision is that of determining the relationship under which the locum tenens is to assume management of the office. Your own attorney can best describe the practical aspects of this problem. It is sufficient to say that there is a real distinction between these with respect to liability of the principal party for the acts of the locum tenens, and with respect to his power to bind or otherwise obligate his absent confrere. In deciding this relationship, consideration must necessarily be given to the extent the locum tenens is to control the practice. For example, may he move the office acting upon his best judgment alone? Or may he make such purchases to the office account as his judgment dictates? Are the costs of operation to be a joint burden, and in any event, what are they?

Financial Arrangements

Whether the locum tenens is reimbursed on a salary or drawing basis, arrangements must be made with respect to handling withdrawals, the financial records to be kept, collection policy and obligations of locum tenens with respect to accounts receivable of the physician.

Locum Tenens to Give Entire Time

As an essential provision of the contract, provisions should be made with reference to the amount of time that the locum tenens is to devote to the practice. Is he to give his entire time and not to engage in any business which would detract from his abilities to serve the community professionally?

Costs of Operation

If the salary or drawing arrangement with the locum tenens is to be based on the percentage of net income after payment of operating costs, items of costs should be specified so nearly as can be determined. If the physician should own his own office, it is only proper that a rent basis for use of the office be established, and such items as light, heat, wages, insurance, supplies and equipment and the like should all be taken into consideration.

The physicians must likewise determine their policy with reference to accounting for collections for services rendered prior to execution of the agreement by the departing physician. Are these to be considered income under the contract or are they excluded?

Restriction on Practice After Termination of Agreement

Wisconsin recognizes the validity of clauses restricting practice after termination of a contract of employment. Your attorney may refer to the Wisconsin Statutes (1959) Section 103.465 and the case of *Lakeside Oil Company, Inc. v. Slutsky* (1959) 8 Wis. 2d 157 and the cases cited therein. The rule in Wisconsin requires that a restrictive covenant not to compete after a term of employment should be reasonably necessary for the protection of the legitimate interests of the employer and at the same time should not be oppressive and harsh on the employe or injurious to the interests of the general public. An unreasonable restraint is void and unenforceable even to those parts of the restraint which would constitute a reasonable restraint.

Therefore, great care should be taken when drafting such a clause so as to make the restraint fit within the Wisconsin rule.

Termination

A provision for termination of the contract should be made. At the option of the party a definite date may be selected or termination can depend upon the time when the absent associate returns, or may be of indefinite duration, and terminable upon sixty or more days' notice. In any event it should be stated that failure on the part of the locum tenens to carry out in good faith the provisions of the contract should be cause for termination without notice.

Miscellaneous Matters

Other matters which a physician may desire to pass upon may include questions concerning the handling of certain business and personal matters of the absentee member, as well as the form of stationery, billing head, prescriptions, liquidation after termination of the agreement of accounts receivable arising during the operation by the locum tenens of the practice, care and replacement of medical instruments and the like.

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin.

1. **Interprofessional Code**

   An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

2. **Civil Defense Manual for Mobile Medical Team Personnel**

   An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.

3. **Code of Necropsy Procedure**

   A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

4. **Guide for the Development of a Local or Regional Rheumatic Fever Program**

   Recommendations for a model rheumatic fever program emphasizing the convalescent home, diagnostic and follow-up clinics, and a home-service plan.

5. **Hearing Conservation Programs for Wisconsin Industries**

   Some recommended standards and principles for providing a hearing conservation program in industry.

6. **Occupational Health, A Guide for Medical and Nursing Personnel**

   General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.

7. **Medical Care of Migrant Agricultural Workers**

   A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.

8. **Guide to Immunization Planning**

   An approved guide including recommended procedures for routine immunizations, parental responsibility, physician responsibility, medical society responsibility and steps for successful community planning.

9. **A Guide for Physicians, Hospitals and News Media**

   A discussion of news relationships between physicians, hospitals, newspapers and radio and television stations. It includes information concerning patients, physicians and county medical society news, health educational efforts and advice on the use of the title "Doctor."

10. **Inspection of Medical Records**

    An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.

11. **School Health Examinations**

    A guide for physicians and school authorities in establishing a program of school health examinations.

12. **School Vision Screening Program**

    An outline to facilitate the development of a program to detect significant visual defects among school children.

13. **Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers**

    A list of the objectives of the State Medical Society in devising the Wisconsin Plan and the conditions under which insurance carriers may participate in that plan.

14. **Guide to Intepretation of Chapter 484, Laws of Wisconsin, 1959**

    Relating to fee splitting between physicians and others.

15. **The Doctor's Role in Adoptions**

    A reprint of three Wisconsin Medical Journal articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

NOTE: The January Blue Book issue of the Wisconsin Medical Journal is a handy reference on medico-legal subjects. Keep this issue and refer to it often.

Some of Your Income Can be Taxed At Only 20 Per Cent

Ten examples show you how the short term trust works

THE tax laws do contain some provisions which allow high income taxpayers to escape or reduce income taxes. The short term trust is one of these. Its use allows a high bracket taxpayer to rid himself of his most heavily taxed income in his highest income earning years. By creating a trust for 10 or more years the income non-taxed at the physician's top rate is taxed instead to a lower bracket trust or beneficiary. Then, in later years when your income is lower, you get your property back and the right to the income from it.

Here is a partial list of what you can accomplish for your family by setting up a short term trust:

(1) build a retirement fund
(2) build an educational fund for children
(3) support dependent relatives
(4) set up a son's business or provide daughter's dowry
(5) purchase life insurance for children
(6) build funds to insure liquidity of your estate upon your death
(7) transfer assets to grandchildren
(8) purchase real estate
(9) shift capital gains
(10) fund purchase of partner's business for benefit of son.

What you do is simply turn over income producing property to a trust which you create by a written agreement between you and a trustee. The trust must last for 10 or more years. The agreement can permit the trustee to accumulate the income during the 10 year or longer period and then distribute it to beneficiaries named in the agreement, or it can be distributed to them currently each year. It will be taxed to the trust if the income is accumulated or to the beneficiary if distributed currently. At the end of the period of the trust, the property comes back to you and you again become entitled to the income.

Setting up a trust is a gift for gift tax purposes. But if the trust is to last 10 years the value of the 10 year gift is only about 30% of the value of the property. Furthermore, most taxpayers haven't used up their lifetime federal gift tax exemption of $30,000. So the gift tax should not be too much of a problem to most taxpayers.

You'll need a lawyer to set up your trust and quite probably you'll want to discuss it with your accountant and investment broker as well as a bank trust officer.

Illustrations of Income Tax Savings Possible

Taxable Income of Creator of Trust:	*Tax Savings if Trust is Taxed and Property Produces Annually:*				*Tax Savings if Beneficiary* is Taxed and Property Produces Annually:*			
	$1000	*$2000*	*$3000*	*$5000*	*$1000*	*$2000*	*$3000*	*$5000*
$10,000	$ 80	$140	$ 142	$ 106	$198	$278	$ 313	$ 362
14,000	120	220	262	306	238	358	433	562
18,000	160	300	382	506	278	438	553	762
20,000	160	300	422	586	278	438	593	842
24,000	200	380	542	786	318	518	713	1042
28,000	250	480	692	1026	368	618	863	1282
32,000	290	560	812	1236	408	698	982	1492
50,000	410	800	1172	1876	528	938	1343	2132

* Assumes Beneficiary has no other income.

Examples of How the Short Term Trust Works:

1. Retirement Fund or Deferred Compensation Plan

You *can't* set up a short term trust for *your own* benefit. But there is nothing to prevent you from setting one up for your wife. You don't want the income paid out currently to your wife because that would cause it to be taxed at the same high rates applicable when you and your wife file joint returns. So you give the trustee the discretion to accumulate the income for her. It is then taxed to the trust at the 20% or 22% rates. At the end of the term of the trust the income is paid to your wife and she then helps support you and your family out of this fund.

If you are a 50% bracket taxpayer and you put $50,000 of securities paying an average of 4% annual return, you can annually build up a retirement fund from income tax savings alone of about $600.00. Assuming the trustee reinvests this saving during a 15 year period a fund of approximately $12,000 will have been built up just out of the tax savings. And you get back your $50,000, plus any principal growth, at the end of the 15 years.

Put another way, the trust can build up a fund, *after taxes*, of about $30,000 during the 15 year period. To have built a similar $30,000 fund with your 50% post tax dollars you would have needed to invest a fund of $85,000 instead of the $50,000. At the end of the 15 years, your wife can take the $30,000 and invest it, spend it, or buy an annuity.

2. Education Fund for Children

Many parents set aside funds annually for their children's college education. If you are a 50% taxpayer it takes $2,000 of income to set aside $1,000 for your children's education. Instead, if your children are young enough so that the 10-year minimum period of a trust ends before their education is completed, you can put income producing assets into a trust which accumulates the income and distributes it to your children at the end of the 10 years. They can then use it for their education. Doing it this way requires about $1,200 annual earnings to set aside the same $1,000.

You must be careful not to have the income used for the support or education of your children while it is still in trust. If this is done, the income will nonetheless be taxed to you. In our illustration, the income is *not* used until the trust is ended, so there is no problem.

During the period of the trust, the income could be reinvested in other securities or in endowment or life insurance policies payable or cashable at the end of 10 years.

You can even cut down the 20% tax payable on income earned by a trust for the benefit of your children if the trust can pay out to the children up to $599 annually. This amount could be put into a savings account for each child. The $599 paid out annually would escape tax entirely because it is less than the $600 exemption of your child.

3. Dependent Relative's Support

A short term trust can save you money if you are supporting a relative whom you have no legal obligation to support. A mother-in-law, or brother or sister are examples.

Assume you give your mother-in-law $200 a month to live on and that you are in the 50% bracket. This requires $400 of pre-tax monthly income. If your mother-in-law has no taxable income of her own, you can set up a trust paying her $200 per month for 10 years, or her lifetime, whichever is the lesser, and save yourself about $2,400 a year in income tax.

You would lose the exemption of $600 for your mother-in-law, but this would merely reduce your $2,400 tax saving by $300.

4. Increasing your Estate's Liquidity

Income from a trust you set up can't be used to pay premiums on policies insuring *your life*. But there is nothing to prevent your wife from using *her funds* to create a trust to pay premiums on life insurance on your life. The beneficiary of this trust created by your wife could be your children. You could empower the trustee, in the event of your death, to use the life insurance proceeds collected by it to purchase non-liquid assets from your estate. Thus you would have the life insurance cash available to your estate. Through this perfectly legal device you can get almost double the amount of insurance purchased for the same amount of pre-tax dollars.

5. Purchase of Life Insurance for Children

If you wish to get your son or daughter started in a life insurance program so as to get the benefit of low premium rates, consider payment of these premiums through a short term trust.

The trust can do it cheaper than you can because it is being done with low taxed dollars.

If you wanted to transfer a $25,000 paid-up policy to your 11-year-old son when he reached the age of 21, you could transfer $35,000 of 4% securities to a trust and the post tax income would be enough to finance a 10 pay life policy. If you are a 50% taxpayer it would have taken $70,000 of securities to produce enough after tax dollars to do the same thing.

Fewer funds, of course, need be put into the trust if you wish to finance lower premium policies during your child's minority such as an ordinary life policy.

6. Using Borrowed Funds to Set Up a Trust

Tax-wise it would be advantageous to you to borrow money and place the loan proceeds in a short term trust.

Assume that you could borrow $100,000 at 5% for 10 years and that you were in a 50% tax bracket. Because you now have an interest deduction, you have actually cut your income tax by $2,500 annually, so the $5,000 interest you pay will only cost you $2,500. The trust will have annual income of $5,000 if it also earns 5%, on which it will pay a tax of $1,074, but $3,926 of income, plus the income on reinvestment, can be accumulated annually for designated beneficiaries. At the end of the 10 years you get the $100,000 back plus any principal growth and you can repay the loan. Subtracting the interest cost to you of $2,500, the $3,926 nets out at an annual gain of $1,426.

This arrangement could be varied for purposes of buying or building a medical arts building or other rental property. You could borrow money to buy or erect the building and then transfer the building to a trust. If it is a medical arts building, you could lease it back from the trust. You must continue to pay the principal and interest installments on the mortgage rather than the trust; otherwise you will be taxed to the extent trust income is so used.

7. Grandfather Trusts

If you are a grandfather and want to protect your son's wife and children against the untimely death of your son in the years when he is getting started, you can do it advantageously with short term trusts for the benefit of your grandchildren and daughter-in-law set up to finance life insurance on your son's life. At the end of the 10 or 15 years, your son ought to be in a position to continue the premiums himself.

8. Shifting Capital Gains

If for example, you have property presently worth $10,000 that is expected to multiply in value in a few years, you can divert the capital gains tax from yourself to a trust or its beneficiary, with a substantial resultant saving.

9. Setting up a Son's Business, or Helping Out Newlyweds

Today many adult sons and daughters need help in the early years of their marriage or business careers. You can provide through short term trusts the same help with much less dollar outlay.

Suppose your daughter is 21 years of age and about to be married to a medical student and that you are in the 50% bracket. Suppose further you want to give her $1,000 a year. You can transfer securities or income property to a trust which pays all the income to her.

If you give her this out of your own pocket it is costing you $2,000 a year of income because you first must pay Uncle Sam $1,000 of tax.

If, on the other hand, you set up a trust for her benefit and transfer into it securities producing $1,000 of income, your daughter will still be receiving the $1,000. You, however, will actually be increasing your spendable income by $500! This is so because you have cut your income by $1,000 thus saving half of this in income tax. True, your income is also down by $1,000 but this is offset by your not having to give your daughter $1,000 any longer.

Typically your daughter will have little or no tax to pay, so this will be no deterrent.

10. Purchase of Partner's Business for Benefit of Son

If you have a son interested in coming into a partnership with you, and your partner had no son interested in doing likewise, purchase of life insurance on your partner's life can be advantageous to all concerned.

If a partnership buy and sell agreement were set up to allow your son to buy out your partner's interest at his death, the insurance on the partner's life necessary to fund the purchase could be financed by means of a short term trust set up by you, taxed at 20%.

* * *

These trusts are recognized under Wisconsin income tax laws as well. While the foregoing examples are only of federal tax savings, considering Wisconsin will only increase the total tax savings.

* * *

Remember that short term trusts lasting for 10 or more years are primarily income tax savers. If you should die during the term of the trust, some death taxes would be saved depending on whether death occurred early or late in the term.

Remember, too, that the creation of a trust is a gift of the right to receive the income for the term of the trust. Its creation may or may not result in a gift tax being payable.

Remember that setting up these trusts requires expert tax advice from a lawyer and accountant.

"Good Samaritan"

AT 6:25 A.M. on August 1, a truck loaded with Jamaican migrant workers and an auto carrying two Wausau youths crashed almost head-on near Columbus.

Within seconds 25 persons were injured, most of them lying on the highway, "piled up like cordwood." The stakebody truck had tipped over, falling on some of the workers. Six were in serious condition, the remainder had injuries to a lesser degree. All required medical attention.

In an auto directly behind the truck was Dr. C. J. Picard, Superior, who was returning from a medical meeting in Chicago. He had no medical kit, no first aid equipment, no bandages.

However, he did have something these people greatly needed—his knowledge of medicine.

Thus, the Superior physician found himself in an extreme example of the "Good Samaritan" situation which has recently been the subject of much discussion at medical meetings in Wisconsin.

The question: "Is the physician rendering aid in such a situation vulnerable to legal action?"

It is Doctor Picard's personal opinion that, despite the possibility of legal action, no physician would fail to give the best attention that he could to a roadside emergency situation if no one else is present who could be reasonably expected to do so.

Thus, the doctor immediately stopped his car and took charge of the first aid. He first determined which of the injured were in critical need of immediate hospitalization, a task made more difficult by the fact that some were underneath the truck. The most serious cases were dispatched to the Columbus Hospital in private vehicles and ambulances.

Law enforcement officers did not arrive for 45 minutes, and thus the doctor was the controlling authority on the scene for that length of time. Most of the first aid treatment was completed when they arrived.

He spent an hour and one-half at the accident scene before all the victims were dispatched to more definitive treatment under the care of other physicians.

Did the doctor have any alternative, other than the action he took? According to Stephen E. Gavin, Jr., legal counsel to the State Medical Society, "Even though he be the only physician available and the emergency requires medical attention, the physician is under no duty to undertake treatment and, thus, would be absolved from liability were he to refuse treatment."

Doctor Picard feels that, although he had a choice legally, the moral obligation required the action he took.

What then became his legal position once this decision to stop and render aid was made? "Once he undertakes treatment," according to Attorney Gavin, "he is under a legal duty to do that which the occasion demands within the usual and customary practice among physicians and surgeons in similar localities and under similar circumstances. Failure to meet that standard of care could subject him to liability."

"It is clear, of course," Gavin continues, "that the lack of facilities, equipment and assistance for diagnosis and treatment in a roadside situation would be given full recognition in evaluating the standard of care to which the physician would be held."

Doctor Picard feels that concern by physicians at the present time is stimulated by the realization

that good care is difficult to render without proper and adequate equipment and supplies.

Individual physicians, through their medical organizations, have been expressing concern in Wisconsin. The Wood County Medical Society voted in June, 1960, to favor legislation making a physician giving emergency care on the road immune from legal suit. "We do not feel this is just, to be liable when we give emergency care under this type of situation," stated Dr. James R. Heersma, secretary of the society.

The Wisconsin Academy of General Practice, at its annual meeting in September, passed a resolution urging "Good Samaritan" legislation. The resolution was introduced by Doctor Picard, who is chairman of the Board of Directors of the Academy.

Nor is concern limited to Wisconsin physicians. California passed such a law in 1959. Similar legislation has been defeated in New York, Virginia and Mississippi. Maryland is considering a bill for the next legislative session and Illinois and Indiana are contemplating legislation.

"Personally, I have doubts as to the need for such legislation" states C. Joseph Stetler, director of the Legal and Socio-Economic Division of the American Medical Association. "I believe that there are few so-called 'Good Samaritan' cases wherein the doctor renders only emergency roadside care to an automobile victim and is rewarded for his humane act by lawsuit."

Mr. Stetler knows of only two cases within the past year where litigation has followed a "Good Samaritan" act. "In one instance the physician sent an exorbitant bill for his services even though he did not render the follow-up treatment," he said. "In another case, the physician continued treatment when he should have referred the patient to a specialist."

Bert A. Davis of The Medical Protective Company, Fort Wayne, Indiana, agrees with Mr. Stetler: ". . . if we confine consideration to cases involving accident victims exposed in ordinary activities, such as automobile accidents, incidence is practically nil."

States Dr. D. N. Goldstein, editorial director of the *Wisconsin Medical Journal*, "I do not believe that the problem is a great one. In fact, I think it is being somewhat exaggerated." He added that he has heard of no case in Wisconsin where a "Good Samaritan" act resulted in a lawsuit.

For those who disagree with the above statements, there is another major hurdle. As an abstract idea, the "Good Samaritan" law encounters little argument. However, as a legal concept there are many questions that remain to be answered.

The California law, enacted as a part of the state's "Business and Professional Code," reads as follows:

"No person licensed under this chapter, who in good faith renders emergency care at the scene of the emergency, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering the emergency care."

This bill, with minor changes, is being used as a pattern for legislation in other states. For example, the Mississippi bill used the same wording but would have extended the immunity to "transporting said injured person to a point where medical assistance can be reasonably expected."

Is such a law constitutional? "There could be question under the Fourteenth Amendment to the Federal Constitution that this immunizing statute is class legislation," points out Mr. Davis of The Medical Protective Company.

In the opinion of Mr. Stetler of the AMA, all bills introduced thus far have been "drawn so broadly that I have serious doubts as to their constitutionality under the state constitutions."

For example, the California law could ostensibly apply to any type of negligent treatment rendered by a physician, provided that he acted in good faith and an emergency situation existed. On the other hand, the unlicensed intern or resident is not covered.

When and where does the "emergency" cease to exist? Under the California law, there is a question of interpretation as to whether the "scene of emergency" also includes the ambulance trip and continues until the injured person is turned over to qualified medical personnel.

Resolution passed by The Congress of Delegates of The Wisconsin Academy of General Practice, September 18, 1960.

WHEREAS, highway accidents continue to be a leading cause of disability and death, and

WHEREAS, the Doctor of Medicine is frequently called upon to administer first aid treatment to the victims of highway accidents, and

WHEREAS, under present laws, a physician rendering aid under such circumstances is unprotected against unjust suits charging him with assault, unauthorized treatment or malpractice, and

WHEREAS, the knowledge of his vulnerable position might dissuade a physician from employing the heroic measures occasionally necessary to save life.

Therefore, the WISCONSIN ACADEMY OF GENERAL PRACTICE urges that protective legislation be passed to enable physicians to render first aid to victims of highway and other accidents without fear of suits alleging assault, unauthorized treatment or malpractice and that a copy of this resolution be sent to the Governor, the Attorney General and to each member of the Wisconsin State Legislature.

Also, contracts between physician and patient in which the latter absolves the physician from any liability for malpractice in the future have been questioned on grounds of public policy. A statute to the same effect might be challenged on the same grounds, although, generally, it is the legislature which is the final arbitrator of what constitutes sound public policy.

The answers to these questions lie in court interpretation, and to this date no instance has come up in California to test the law.

Another consideration does not involve the merits of such a law, or even the possibility of having such legislation enacted, but rather its effect on public opinion. It becomes increasingly evident that medicine must be cognizant of public opinion in accomplishing any goal or objective.

Attorney Gavin, in pointing out that the physician has the legal right to drive right past the accident scene, states, "... it might well be in the public interest that he be granted a limited exemption from personal responsibility in specific circumstances."

However, would it be interpreted as being in the public interest, or as a special privilege for physicians? Misinterpretation of medicine's motives is not unusual in modern public opinion.

As a final consideration, would the proposed "Good Samaritan" law give the physician any immunity which he does not presently have?

"The doctor who undertakes the treatment of a patient under any condition may relieve himself of responsibility for continuing with the patient at any time when that can be accomplished without injury and damage to the patient," states Mr. Davis.

"It is my opinion that no immunity statute could be drawn to stand the test of its constitutionality if it undertook to give the doctor anything more—and the present state of law gives him nothing less."

For an issue which seems quite simple on the surface, the question of a "Good Samaritan" law becomes quite complex.

Is such a law needed? Does the lack of court cases make it unnecessary or does the possibility that such a case could arise make it mandatory?

If physicians feel a "Good Samaritan" law is needed, would it be possible to draft legislation which would accomplish the goal and still stand the test of constitutionality and established jurisprudence?

AMENDED IN ASSEMBLY JUNE 5, 1959

CALIFORNIA LEGISLATURE, 1959 REGULAR (GENERAL) SESSION

ASSEMBLY BILL No. 2873

Introduced by Mr. Rumford

May 4, 1959

REFERRED TO COMMITTEE ON PUBLIC HEALTH

An Act to amend Section 2144 of the Business and Professions Code, relating to emergency medical treatment.

The people of the State of California do enact as follows:

1 SECTION 1. Section 2144 of the Business and Professions
2 Code is amended to read:
3 2144. Nothing in this chapter prohibits service in the
4 case of emergency, or the domestic administration of
5 family remedies, nor does this chapter apply to any com-
6 missioned medical officer in the United States Army,
7 Navy, or Marine hospital, or public health service, in the
8 discharge of his official duties, nor to any licensed dentist
9 when engaged exclusively in the practice of dentistry.
10 No person licensed under this chapter, who in good
11 faith renders emergency care *at the scene of the emer-*
12 *gency*, shall be liable for any civil damages as a result of
13 any acts or omissions by such person in rendering the
14 emergency care.

Inspection of Physician and Hospital Records

An Interpretation of Chapter 301; Laws of 1959

by the

STATE MEDICAL SOCIETY OF WISCONSIN and the WISCONSIN HOSPITAL ASSOCIATION

August, 1960

[No. 659, A.]

CHAPTER 301, LAWS OF 1959

AN ACT

AN ACT to create 269.57 (3) and (4) of the statutes, relating to medical evidence.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

269.57 (3) and (4) of the statutes are created to read:

269.57 (3) No evidence obtained by an adverse party by a court-ordered physical examination or inspection under sub. (2) shall be admitted upon the trial or by reference or otherwise unless true copies of all reports, photographs, records, papers and writings made as a result of such examination or inspection and received by such adverse party have been delivered to the party claiming damages or his attorney not later than 15 days after the said reports, photographs, records, papers or writings from any such court-ordered physical examination are received by the said adverse party, provided that in an action for recovery of personal injuries, the party claiming damages shall in return deliver to the adverse party against whom the action is brought a true and correct copy of all reports of each physician who has examined or treated such person with respect to the injuries for which damages are claimed.

(4) Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, the physician, surgeon or other person having custody of any medical or hospital reports, photographs, records, papers and writings concerning such care or treatment shall forthwith permit the person designated in such authorization to inspect and copy such records. Any person having the custody of such records who refuses to comply with such authorization shall be liable to the person receiving such medical care and treatment for all reasonable and necessary costs of obtaining such copies and inspection and for attorney's fees not to exceed $50 plus costs.

Introduction

Chapter 301 as passed by the 1959 Wisconsin Legislature and signed by the Governor, created Subsections (3) and (4) of Section 269.57, Laws of Wisconsin. The new subsections affect the right of access to physician and hospital records relating to patient care.

It is generally agreed that physical ownership of medical and hospital records rests with the physician and the hospital. However, since the doctor-patient-hospital relationship is a contractual one, the patient has a right of access to relevant records concerning his care and treatment.

Because physicians, patients, hospital staff personnel and others are not clear as to their respective rights and obligations, and because there is uncertainty as to what constitutes the "hospital record," representatives of the State Medical Society of Wisconsin and the Wisconsin Hospital Association have jointly undertaken an interpretation of this subject.

Upon the recommendation of attorneys for the State Medical Society of Wisconsin and the Wisconsin Hospital Association, approved by the Council of the State Medical Society and the Board of Trustees of the Wisconsin Hospital Association, the following recommendations and suggestions regarding the hospitals' and physicians' responsibilities under Chapter 301, Laws of Wisconsin, 1959, have been prepared as a guide:

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1. Upon being presented with an authorization form for the inspection of medical records, physicians and hospitals must assure themselves that the patient did *in fact* sign the authorization, and that he was of *legal age* and had the *mental capacity* to know what he was signing. A minor or incompetent must act through his guardian, and the hospital or physician must take such precautions as are necessary to satisfy themselves that those signing are thereby authorized to effect the release of the records of the patient.

The hospital or physician must be assured that the *person presenting* the authorization to inspect or copy records is the *identical person named* in such instrument. So long as there is any prudent or reasonable doubt as to the identity of a person presenting authorization to inspect or copy records, the hospital administrator, or his representative, or the physician, depending upon which place the authorization is presented, is warranted in refusing to honor such authorization. The same is true if there is any substantial question as to the mental capacity of the patient or as to the authenticity of his signature.

On being satisfied that the authorization presented is properly signed, as previously outlined, and that the person presenting it is the person named therein, and that no question of mental capacity or of minority is involved, it then becomes the duty of the hospital, institution or physician to permit such person to inspect and copy "medical or hospital reports, photographs, records, papers and writings" concerning the care and treatment of such patient.

It is first necessary to determine what must be made available for inspection and/or copying. It is believed that under a strict interpretation of subsection (4) of the statute, the physician's records (office or hospital), and the hospital clinical record or chart should be presented. In the case of x-rays there seems to be some disagreement among legal authorities that they are part of the medical record as such or are technically photographs. It is advised that x-rays *not* be released unless by court order, and that they be inspected *only* under proper supervision (in the case of a hospital or other institution by a qualified physician, or in the event of his unavailability, by a person designated by the administrator; in the case of a physician's office, by the physician in charge, an associate, or the designee of either).

Administrators and physicians should be cautioned that the copies of the records should be made only under properly authorized supervision, and that the originals of the records cannot be taken out of their custody at any time *except* under court order.

To avoid substantial wasted administrative or professional time with the examination and copying of records relating to illnesses which do not fall within the inquiry of the patient, it is strongly urged that the administrator or physician request that the illness and the period of time both be specified in the written authorization, or be agreed to by the person presenting such consent.

2. One of the results of the increasingly comprehensive services of the modern hospital, especially teaching institutions, is the development and maintenance of *two* types of records relating to a patient. One relates directly to his care and treatment, and is the direct professional reponsibility of the attending physician and of those acting under him. The other has sometimes been described as "educational records," which are typically made by nonmedical personnel as part of their training, or at least for purposes not directly related to the "medical care and treatment" of the particular patient.

It is believed that no record other than that made or approved by the physician in charge, or by a consultant, or resident, or by a registered nurse who is recording her acts or observations made pursuant to special or standing orders, is one which relates to the "medical care or treatment" of the patient, as that phrase is used in the new statute.

Consistent with the above conclusion, it is believed (1) the notes of the attending physician, consultants, and of a resident, plus (2) the patient's chart, are *all* that make up the official hospital record. X-rays have been treated earlier in recommendation 1 herein. Any *other* writings should be kept *separately* but *not* as a part of the patient's official record, for the reason that the persons making such writings are not professionally responsible for the patient, or are not licensed to practice medicine, and are not recording acts or observations made pursuant to orders of the attending physician. Such writings are not authentic records relating to the care or treatment of the patient.

There has been understandable apprehension on the part of some hospital administrators and physicians that the production for inspection or copying of nurses' notes, or of comments by interns, social workers, and others, could embarrass or damage the interests of the patient, the hospital, or the attending physician. It is emphatically recommended that medical staffs and hospital administrators embark on an immediate, intensive, and continuing program of education which has as its sole purpose the maintenance of patient records which are limited to physical findings, diagnosis, treatment, prognosis, and to acts or observations made in the course thereof, or made pursuant to standing or special orders. If medical staffs, nursing staffs, and personnel under training, will so limit what they write, whether as part of the official patient record, or as part of an educational record, such apprehensions will disappear.

Again, emphasis should be placed on the importance of *physically separating* writings relating to a patient into (1) those made by or under the authority of the attending physician, consultant, or resident, and (2) those made for educational, training, internal, or other collateral purposes. The two categories of writings should be *separated* when the patient is *discharged* from the hospital, since only the first of them relates to the "medical care or treatment" of the patient, and is the only type of record called for by the new statute, and the only type which the physician or hospital should present for inspection or copying.

3. If an authorized person demands more than the above, it should be *refused* and a court allowed to rule on the request. If hospital administrators,

CONSENT TO EXAMINATION OF PHYSICIAN'S RECORDS

To Dr. _____

I hereby authorize and request you to furnish a copy of the medical records of _____

_____, covering the period from _____ 19____ to
(State name of patient or "myself")

_____ 19____ or to allow those records to be inspected or copied by _____

_____. I hereby release you from all legal responsibility or liability that may arise from the act I have authorized above.

Signed _____

Witness _____ Date _____

CONSENT TO ACCESS TO HOSPITAL RECORDS

o _____, Hospital Administrator, _____ Hospital.

I hereby authorize you to furnish a copy of the hospital records of _____

_____, covering the period from _____ 19____ to
(State name of patient or "myself")

_____ 19____ or to allow those records to be inspected or copied by _____

_____. I hereby release _____ Hospital and you personally from all legal responsibility or liability that may arise from the act I have authorized above.

Signed _____

Witness _____ Date _____

physicians, and interested members of the public cannot determine what is embraced in the phrase "medical or hospital reports" relating to the "care or treatment" of the patient, a judicial determination of this question may well become necessary and even desirable.

4. It is further believed that the authorization to inspect and to copy is *personal* to the patient, and for that reason *does not survive* his death. Thus an authorization signed by an executor, administrator or member of a deceased patient's family has no legal effect under subsection (4) of the statute.

5. The potential liability of a hospital for defamation, and the statutory liability of the physician for "wilful disclosure" of professional secrets, deserve brief comment. Both are under the primary duty of not permitting the operation of the statute to be broader than its wording.

Section 269.57 (4) does *not* in words or by implication, give a right to remove any records from the hospital, institution, or a physician's office, the records being the property of the hospital, institution or physician.

As an act of prudence, the hospital or physician should require that inspection and copying be carried on in the presence of a custodian (hospital or physician), or the representative of either. The statute does not require a hospital, institution, or physician to copy any records at the request of a patient or his representative. If a request is made by a patient or his representative, and the request is granted, the hospital, institution, or physician making such copy is entitled to make a reasonable and realistic charge for doing so.

As a precautionary measure to hospital administrative personnel and to physicians, it is suggested that under no circumstances should copies of any medical or hospital reports, which are prepared by a representative of the patient, be signed, initialed or subscribed to in any manner that may indicate authenticity and accuracy of such copies.

6. Few people, other than medically trained personnel, will know what is important in a hospital or medical record. For that reason a hospital librarian or other authorized person, or a physician, may in some situations be able to satisfy a request by making inquiry as to what the patient or his representative really wants from the records, and reading the material relative to the inquiry. This may save a great deal of examining, copying, and inconvenience to everyone concerned.

7. The word "forthwith" used in connection with the right to inspect and copy records does *not* mean "immediately," but "as soon as the convenience of an administrator, a record librarian, or a physician, *reasonably* permits," after taking into account the urgency of prior demands on their time and personnel, and whether advance notice had been given of the demand of the particular patient.

8. When there is any indication that legal proceedings may ensue, the hospital, institution or physician served with a proper demand to examine or copy a patient's records should promptly notify its insurance carrier of this fact, and also the general attorney of the hospital, institution or physician. It is recommended that, in the interest of the patient, the hospital, and the physician, the knowledge of any such demand be given by the person receiving same to the other interested parties.

Since no wording appears in the statute prescribing the form for authorization to inspect and copy a patient's records, a model form is not being recommended. It is believed that authorized persons, be they attorneys, insurance adjusters, relatives, or others will familiarize themselves with the statute and will prepare their own authorization. However, as a suggested guide for hospitals and physicians, there are sample forms attached which generally meet the requirements set forth in recommendation No. 1 herein. It is not to be construed as a model authorization form, but merely as a suggested guide.

DO YOU EMPLOY FOUR OR MORE PERSONS?

If you do, then you must pay unemployment insurance taxes.

Employers, including physicians, who employ four or more persons for some portion of the day on at least one day in each of 20 weeks in a calendar year are subject to both the state and federal unemployment insurance tax.

The combined state and federal tax is 3% of the first $3,000 of annual wages paid to all employees, of which 2.7% is payable to the state and 0.3% to the federal government.

The report and payment to the federal government is due by January 31 of the subsequent calendar year. Reports and payments to the state are due quarterly during the year in the months of April, July, October, and January. The exact date within the month is set by the state. These reports and payments are due regardless of whether the employer has been notified by either of the governments or has received tax forms.

If a physician or clinic has employed four or more persons in any portion of each of 20 weeks during the current year and has failed to pay the quarterly payments to the state, this should be done promptly so as to keep at a minimum any penalties and interest which will be due. Payment of the federal unemployment insurance tax should be made by January 31.

How to Complete a Death Certificate

The death of a patient requires at least one legal act by the physician. How he does it can be very important.

MOST death certificates are made and signed by a physician. The reason is obvious—most deaths occur with a physician in attendance. This final act by the physician is not a mere routine.

A death certificate is vital in a number of ways. In Wisconsin a human corpse may not be buried or otherwise disposed of before a proper death certificate is made and signed by a competent person. Burial may not take place without a permit for burial or removal. Issuance of the permit depends on a "complete and satisfactory certificate of death."

Here is what the law requires:

1. The certificate shall be made and signed by the physician last in attendance on the deceased.
2. The certificate must specify the time in attendance, the time the physician last saw the deceased alive, and the hour and the day at which death occurred.
3. The physician must state the causes of death in such a way to show the course of disease or sequence of causes resulting in death, and the duration of each.
4. Indefinite and unsatisfactory terms indicating only symptoms of disease or conditions resulting from disease are not acceptable. A certificate containing only such terms will be returned to the physician for correction and definition.
5. The causes of death which may be the result of either disease or violence must be carefully defined. If violence is the cause of death, its nature should be stated, as well as whether it was accidental, suicidal, or homicidal.
6. In case of deaths in hospitals, institutions, or away from home, the physician shall furnish the information required and state where, in his opinion, the disease was contracted.
7. The cause of death and any other facts required must be stated in accordance with the rules and regulations of the State Registrar.

Whoever makes and signs the death certificate must be acquainted with the facts. There may be instances in which the physician last in attendance does not know the cause of death. He may not possess all the information needed to complete a certificate. As a rule, the attending physician does not find it necessary to make a special investigation in order to prepare a certificate. But when a physician is called in to prepare a certificate for a patient he was not attending, he should not insert the information required without first making whatever investigation he feels necessary.

The local registrar may make and sign the certificate if all three of the following conditions are fulfilled:

1. There have been no attending physicians
2. The person desiring to dispose of the body has made request for a burial or removal permit
3. It is impossible to obtain a physician to investigate the cause of death and prepare and execute the certificate "early enough for the purpose."

"Early enough for the purpose" has not been officially interpreted, but it probably means that the local registrar may act in order to prevent an unreasonable delay in funeral ceremonies. If all three conditions are fulfilled, the registrar may make and sign the certificate, utilizing information supplied by relatives of the deceased or other competent lay persons. However, if a physician *may* be obtained he *must* be obtained. Such a physician's services will be paid for by the person seeking disposition of the body. Payment of the physician is reimbursable from the estate of the deceased person as a proper funeral expense.

The coroner may issue a certificate of death:

1. If he has held an inquest on the body
2. Without a formal inquest, if he has investigated a death falling in any of the following specific categories:
   a. Death occurring in a hospital, sanatorium, public or private institution, convalescent home, or the like
   b. Death under unexplained, unusual, or suspicious circumstances
   c. Homicide
   d. Suicide
   e. Death following an abortion
   f. Death due to poisoning, whether homicidal, suicidal, or accidental
   g. Death following accident, whether the injury received was the primary cause of death or not
   h. Death when no physician was in attendance
   i. Death when a physician refuses to sign the death certificate.

REFERENCES

1. Wisconsin Statutes, 1959, Section 69.38–69.41.
2. Wisconsin Statutes, 1959, Section 69.44 (1).
3. 40 O. A. G. (1951) 476.

The Doctor's Role in Adoptions

Here is what the physician can do to keep sentiment from overruling caution in adoptions

WITH over 2,000 illegitimate children born in Wisconsin each year, it is only a matter of time before the physician is approached by an unwed mother or a married couple seeking a child.

No warning can be too emphatic: Avoid all entanglement with the emotional and legal webs that surround child placement.

The physician's role in adoptions is clear: Suggest immediately that the parties involved consult with either a licensed child welfare agency or an authorized public agency.

Wisconsin laws, long outstanding for the protection of adoptive children, were further strengthened when the legislature adopted a new Children's Code in 1955. Sec. 48.63 (2), Wis. Stats., 1959, prohibits all nonauthorized persons, *including physicians* and attorneys, from any act as intermediaries in finding children for adoption or making placements. In fact, these statutes specify that: "No parent or guardian, except a licensed child welfare agency or public agency authorized to place children for adoption, may place a child in a foster home for adoption without obtaining the written approval of the county court."

Stiff penalties back up the law: Fines up to $500 or imprisonment up to one year in the county jail, or both. See Sec. 48.76, Wis. Stats., 1959.

Here is what the physician can and cannot do:

The Physician

SHOULD ALWAYS urge the unwed mother, prospective parents, or others to consult with either a licensed child welfare agency or an authorized public agency. If questions arise, the physician should consult the Division for Children and Youth, State Office Bldg., Room 385, Madison 2, Wisconsin, the state administrative agency charged with such matters.

REFER CHILD PLACEMENT CASES TO THESE AGENCIES

Licensed Child Welfare Agencies:

*Children's Service Society of Wisconsin, 610 North Jackson, Milwaukee 2.

Catholic Social Welfare Bureau, 207 East Michigan Ave., Milwaukee 2.

Catholic Welfare Agency, 1209 Hughitt, Superior.

Catholic Social Service, Inc., 3200 South Avenue, La Crosse.

Catholic Welfare Bureau, 25 S. Hancock, Madison 3.

Green Bay Diocese Apostolate (Catholic), 131 South Madison Street, Green Bay.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa 13.

Lutheran Welfare Society of Wisconsin, 3126 West Highland Boulevard, Milwaukee 8.

Jewish Family and Children's Service, 2218 North Third Street, Milwaukee 12.

*Family Service, 2059 Atwood Ave., Madison.

*Family Service Association of Beloit, 423 Bluff St., Beloit.

*Family Service Association of La Crosse, 304 Newberg Building, La Crosse.

*Family Service Association of Manitowoc, 705 York St., Manitowoc.

*Taylor Children's Home, 3211 Taylor Avenue, Racine.

Public Agencies:

*Wisconsin Division for Children and Youth, Room 385, State Office Bldg., Madison 2.

*Milwaukee County Department of Public Welfare, Child Welfare Division, County Court House, Milwaukee 3.

Licensed Maternity Homes:

*Martha Washington Home, 6306 Cedar Street, Wauwatosa.

Misericordia Hospital (Catholic), 2224 West Juneau Street, Milwaukee 8.

St. Francis Hospital (Catholic), 1020 Market Street, La Crosse (temporarily closed due to a building program).

St. Mary's Home (Catholic), 403 South Webster Avenue, Green Bay.

*Summit Hospital, Oconomowoc.

Fees for care in licensed maternity homes vary from $130 and up, depending on length of stay, covering prenatal care, confinement, and care after the child is born. Several institutions provide employment opportunities to cover part of the cost of service rendered. Counseling services for unwed parents, both before and after the birth of the child, are provided by social agencies.

* Nondenominational.

MUST NOT suggest to any unmarried mother, other natural parent, or legal guardian any particular foster parents for a child he believes available for adoption.

MUST NOT offer to find foster parents for such a child.

MUST NOT offer to find a child for adoption by prospective foster parents.

MUST NOT place a child with foster parents on a trial or any other basis.

MUST NOT act in any other way as negotiator or intermediary in such matters.

MUST NOT in any other way risk possible violation of the clear terms of the statute.

Professional reputation and ethical standing, as well as a police record, are at stake in the physician's dealings with the unwed mother or prospective parents. Thus, it is absolutely essential that he avoid any conduct which might cause the public to view him as associated with a "black market in babies."

It may help the physician to know that the declared policy of the State of Wisconsin gives paramount concern to the welfare of the child in any adoption procedure. The parents, guardian, and the public interest have secondary consideration. Thus, the Children's Code, by insisting on referral of adoption cases to authorized agencies, offers the physician practical and highly professional recourse in what might otherwise be a dangerous sentimental action.

Sec. 48.78, Wis. Stats., provides that no records kept or information received relative to individuals, their care or legal custody shall be open to inspection or their contents disclosed except by order of the county court. Even the exchange of information between authorized agencies, or social welfare organizations is required to be on a confidential basis.

REFERENCES

Wis. Stats., 1959, Sections 48.01 (3), 48.60, 48.62 and 48.65.

WHAT ARE YOUR RIGHTS IN EMERGENCIES?

Question: Suppose a physician in private practice serves as advisor to his local police department. The department calls him, either to the police station or to a private home, where a belligerent alcoholic is creating a disturbance. The physician gives a hypodermic injection to calm him, without the alcoholic's consent, and with or without the nearby relatives' consent. The alcoholic is believed to be endangering himself or those in his environment. Is the physician within his legal rights as a doctor called by the police?

Suppose a similar sequence occurs with a mentally ill patient. The police are following the physician's orders in these circumstances. To protect the patient and others from the violence of the patient, the physician orders restraints applied. Is he within his legal rights as a doctor called in by the police? Assume that no relative is immediately available to take responsibility of the patient.

Answer: Generally, a physician has no authority to administer a hypodermic injection or any other treatment to a patient without the consent of the patient or someone authorized to act on his behalf. If the patient is mentally incapable of speaking for himself because of intoxication, injury, illness, or insanity, consent must be obtained from someone legally authorized to act on behalf of the patient.

An exception is permitted in the case of an emergency, where the patient's life is endangered. Under these circumstances, the law will presume the patient's consent on the theory that, if the patient were rational and able to make his own decision, he would consent to treatment.

A physician going into a private home has no authority to treat the patient without the consent of the patient, or someone authorized to act on his behalf, unless a bona-fide emergency exists in which the patient's life is endangered. Except with regard to persons committed to state institutions, and other situations where specific statutory authority is granted, the police have no authority to authorize a physician to drug a patient against his will solely because he is creating a disturbance or endangering others. The police have power to restrain such an individual by force, if necessary, although force does not include the use of drugs. However, where a patient becomes so violent that it is necessary to restrain him with drugs, the situation is usually one where treatment can be justified because of a bona-fide emergency. Reference: "The Physician's Legal Rights in Emergencies," J.A.M.A. (Queries and Minor Notes Section) 161:1518 (Aug. 11) 1956.

Problems of the Physician's Widow

DURING 1960 death came to 52 members of the State Medical Society. In every appropriate case, the Society wrote the physician's widow seeking to provide assistance during a trying period. The Society, believing the adage that "an ounce of prevention is worth a pound of cure," suggests that every member give thoughtful consideration to the problems which might face any physician's widow.

Several problems are almost certain to confront the widow who in the days immediately following a physician's death is suddenly pressed into the position of managing the estate and drawing together the loose ends of what was once an active practice. Careful preparation for this eventuality can not only protect the welfare of the family, but ease their burdens at a trying time.

With the death of a physician the widow will be faced with many decisions regarding the collection of outstanding accounts and the settlement of many business matters relating to the physician's practice. Thus, it is extremely important that she proceed slowly acting ordinarily only upon the advice of an attorney. It is obvious that the selection of this attorney and acquaintance between the attorney and the physician's wife is a prerequisite to an easier relationship in event of the physician's death.

Case records of patients and malpractice insurance policies of the physician should not be destroyed for at least three years. Liability for malpractice does not cease upon the death of a physician, and such actions may be started against a physician's estate by filing within a period of three years from his death. The physician's records and liability insurance policies may be the widow's only defense. Every precaution should be taken to insure that these records are kept intact subject to immediate call for at least three years.

Of course, one can expect that the deceased physician's patients will seek care elsewhere. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of his patient. In this event it is wise to insist upon a personal request from the physician and to transmit the record with a cover letter confirming the transfer.

Former patients may seek a continuation of medication prescribed by the deceased physician. This should be carefully avoided because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The deceased physician's narcotic license must be surrendered as soon as possible along with any supply of narcotic drugs. These should be sent to the U. S. Treasury Department, Narcotics Division, 628 East Michigan, Milwaukee, Wisconsin.

In any event, the State Medical Society Office is always available for consultation. Though there may be many who urge speedy settlement of all aspects of a deceased physician's practice, the wisest counsel is found in proceeding slowly and with competent legal advice.

DRIVERS' LICENSES FOR EPILEPTICS

A person subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin on a temporary basis if:

1. He is recommended for a temporary license by any physician licensed in Wisconsin.
2. He is under medical care.
3. While under medication he is free from seizures.
4. His driving is not otherwise a hazard to public safety.
5. His physician recertifies each six months that he is free from seizures.

The physician makes his certification on a combined questionnaire and recommendation form provided by the Motor Vehicle Department. The physician making such a recommendation must be the physician who is rendering treatment to the epileptic patient. The issuance of a temporary license is discretionary with the Motor Vehicle Department. A denial may be reviewed, however, by a special board of five members. Four of these members are designated by the president of the State Board of Health.**

Reference: Section 343.09, Wisconsin Statutes, 1959.

** The fifth member is the Commissioner of the Motor Vehicle Department, and he and any two of the other members constitute a quorum.

A Word of Caution Before Discarding Case Records and X-Rays

PAPER work has many physicians on the verge of hysteria. There's more of it. It costs more to produce. It takes more office personnel. It takes more time. And what's more, the records of it live to haunt you.

Here's what's happening around Wisconsin:

★ A clinic in operation for 20 years has a large room filled to overflowing with bulky case records. Expansion of storage is expensive. But conversion to newer, less space-consuming records would cost over $2,000.

★ Another two-man clinic started three years ago is grumbling over bulky, inconvenient records and the accumulation of paper and is already pushing into valuable examining and laboratory room space.

★ One physician was literally forced out of house and home when his wife objected to records from the home-attached office spilling over into the living room.

Can a systematic destruction program solve this problem? How long should you keep your professional case records and x-rays?

With a couple of limitations, the professional records of physicians are generally considered the property of the physician who makes them. Of course, he must be able to assure the patients that the records are being kept in confidence; and ethical considerations require that he make them available to a succeeding physician upon the request of the patient.

Otherwise, you have a clear property right to your professional records and x-rays. Thus, you have the legal right to destroy them, except when prohibited by statute.

But before you toss the whole "kit and caboodle" into a bonfire, here are a half dozen good rules to remember:

1. Keep narcotic and other prescriptions at least two years. If you don't, you face severe penalty—even revocation of your narcotic license. The State Board of Health prescribes the records you should keep on narcotics. Follow its advice, and you will meet the requirements of both the Wisconsin and federal statutes.
2. Retain all other patient records as long as they have any conceivable value, either to the physician or to the patient—and in no event for less than six years. This, you say, could be forever. That may or may not be. Here are some examples:

★ Premature destruction of professional records and x-rays could obviously be a disservice to the patient and result in great harm in many situations.

★ A patient who has not used your services for many years might return specifically because you had once cared for him. Even if a patient seems to be leaving the reasonable vicinity of your service, you may be called upon to provide a succeeding physician with his records.

★ Your records should be retained for that period of time during which the record of treatment and diagnosis may be needed by the patient in the prosecution or defense of

WHAT WOULD YOU DO?

SITUATION: Mrs. John Jones was diagnosed as cancer, malignant. Prognosis: Poor. She left Wisconsin to live with relatives in Oregon. Six months later she wrote her previous physician, Dr. John Doe, asking that he send her complete medical record to her new doctor in Portland. Doctor Doe protested, saying her voluminous record of care and treatment for the previous five years, including x-rays, would be costly to reproduce.

COMMENT: Doctor Doe has an obligation to make his records available to a succeeding physician at Mrs. Jones' request. The force behind this is mainly ethical, but the failure to provide adequate records with reasonable promptness for the use of the succeeding physician may jeopardize Mrs. Jones' health and thus open a possibility of a malpractice claim where none existed before. On the other hand, Doctor Doe is not required to send his only copies of these records and might reasonably request Mrs. Jones to pay the cost of reproduction for the necessary copies. If there is a question of malpractice involved, consult your attorney, insurance company, or the State Society office.

a legal action or in the establishment of some legal right. Records are of particular importance to the patient in establishing a service-connected disability claim against the Veterans Administration, in determining the mental capacity in a will contest, in evaluating personal injury in an automobile accident, and in determining the extent of disability resulting from an industrial accident in a claim under the Workmen's Compensation Act.

★ Records are vital for defense in malpractice claims against the attending physician and the hospital, if it is involved. Wisconsin statutes require that one alleging a malpractice must assert that claim by institution of legal action within three years of the occurrence of the alleged event. This applies even to those who may be incapacitated by reason of infancy or insanity. Even when no suit has been filed within three years, the patient may still question the value or quality of the professional service as a defense to an action by the physician to collect fees. A collection suit will not then revive the patient's right to damages, but the lapse of that right will not keep him from arguing that the services were so far below standard as to be noncompensable. Such a collection action must be commenced within six years. Thus, if you think it may be necessary to resort to legal action in the collection of your fee, it would be smart to keep your professional records for at least that six-year period.

3. Keep all pertinent records indefinitely as long as there is a known or threatened legal complication such as a malpractice or collection suit.
4. When a suit is actually brought against you by a patient (or someone acting for him), you must preserve all patient records, including x-rays, laboratory reports, and correspondence, until your attorney advises that in his judgment the time is past within which other litigation that might grow out of the first suit could be brought. This may be some time after the litigation has been concluded.
5. If you should bring a suit against a patient, the same time periods must be carefully observed, leaving the final determination to the judgment of an attorney.
6. Records should be preserved even longer than usual if the case is affected by mental incapacity, infancy, or imprisonment of the patient. Rely on your attorney's advice.

POST MORTEM EXAMINATION

Question: Whose consent is required to permit a physician to conduct a post mortem examination?

Answer: Consent for a physician to conduct a post mortem examination is considered sufficient when it is given by the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin.

If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Reference: Section 155.05, Wisconsin Statutes, 1959.

LAW REQUIRES SILVER NITRATE TO PREVENT INFANT BLINDNESS

The state law requires, and the State Medical Society recommends, the continued use of silver nitrate for the prevention of ophthalmia neonatorum.

Some birth certificates filed with the State Board of Health reveal that Wisconsin physicians are utilizing penicillin as a substitute for silver nitrate. However, professional circles still debate the efficacy of substitutions for silver nitrate. The State Medical Society's Committee on Maternal and Child Welfare believes there is not enough evidence to recommend the use of substitutes. The American Medical Association has expressed the same attitude.

Physicians are warned to use only the 1% solutions of silver nitrate prepared by the State Board of Health and distributed free to each physician through local health officers. The law also requires the physician to use the solution as directed in the prepared instructions.

The use of any substitute for silver nitrate in the prevention of ophthalmia neonatorum subjects a physician to a possible fine of $100. In addition, it may subject him to a suit for malpractice.

Reference: Section 146.01, Wisconsin Statutes, 1959.

MEDICOLEGAL INFORMATION

AVAILABLE

Individual physicians or county medical societies may wish to make use of several informational materials and speakers on topics relating to medical-legal problems of physicians.

FILMS

The following films are available upon request to the State Medical Society of Wisconsin. Please allow at least two weeks advance notice if possible. These films were produced by Wm. S. Merrill Co. under direction of the American Medical Association, American Bar Association and American Hospital Association.

"Medical Witness"—Dramatically illustrates use of medical witness in court, providing do's and don'ts for effective testimony. Black and white, sound, 30 minutes.

"Doctor Defendant"—Suggests how the physician can prevent professional liability suits; shows county medical society grievance committee in action. Black and white, sound, 30 minutes.

"Man Who Didn't Walk"—Legal and medical aspects of personal injury case. Shows lawyers for plaintiff and defendant as they establish evidence from physicians, pretrial conference, and summation to jury. Black and white, sound, 30 minutes.

"A Matter of Fact"—Discusses the need for an adequate medical examiners' system versus the presently common coroners' system. Black and white, sound, 30 minutes.

"No Margin for Error"—Portrays certain aspects of physician-hospital activity bearing upon professional liability. Black and white, sound, 30 minutes.

"Chemical Tests for Intoxication"—Deals with the subject of chemical tests for intoxication and the introduction of the results of such tests in court. Black and white, sound, 30 minutes.

SPEAKERS

County medical societies interested in obtaining speakers on medicolegal subjects may contact the State Medical Society, Box 1109, Madison 1, Wisconsin (phone ALpine 6–3101), or the State Bar Association of Wisconsin, 402 West Wilson Street, Madison, Wisconsin (phone ALpine 7–3838).

LITERATURE

Copies of the following materials are available upon request to the State Medical Society of Wisconsin:

★ Interprofessional Code

★ Medicolegal Consent Forms (see January 1958 Blue Book issue of the *Wisconsin Medical Journal*)

★ Test Your A. Q. (Alcohol Quotient), 20 Questions on alcohol

★ Malpractice and the Physician

★ Medicolegal Aspects of Blood Transfusions

★ Medicolegal Aspects of Blood Grouping

Responsibility of the Physician Conducting Pre-Employment Examinations

THE following question is frequently raised by physicians and those interested in pre-employment physical examinations. The answer is provided by legal counsel for the State Medical Society of Wisconsin.

Question. What are the responsibilities of a physician to an employer for whom the physician is doing pre-employment physical examinations, to reveal to the employer conditions known to the physician to exist (such as epilepsy) but of which the physician would have no knowledge in the course of the examination except by previously acquired information in his capacity as the examinee's personal physician?

Answer. Unless the examinee authorizes the physician to disclose to the employer information acquired by the physician in his professional capacity as the examinee's personal physician, the physician should make no such disclosures to the employer.

Opinion. At first sight this question may appear to present a dilemma, but it does so only if the physician and employer have failed to define the physician's responsibilities with sufficient clarity. It should be made clear to the employer at the outset that the physician will limit his reports to such facts as are revealed to him during the examination itself, and will not include information acquired by the physician while treating the examinee as a patient.

The physician to whom this situation is presented is quite likely to feel disturbed by two apparently conflicting legal obligations:

(1) His statutory and ethical obligation to his patient to refrain from "willfully betraying a professional secret;"
(2) His contractual obligation to the employer to disclose all he might know that bears on the prospective employee's fitness for a particular job.

Actually, the physician has only the first of the above mentioned legal obligations. Even if his contract with the employer contained a specific provision requiring the disclosure without the patient's consent of information acquired in the course of professional treatment, that provision would undoubtedly be held void by any court passing upon it, as being contrary to the public policy implied in the protection of secrecy afforded by Section 147.20 (1) (b) of the Wisconsin Statutes.

The real problem, therefore, is not a legal one. Rather, it is a problem in communications. The employer, quite possibly unfamiliar with the physician's legal and ethical obligations to his patients, might find it difficult to understand how the physician could be so lacking in candor as to fail to disclose all information for which the employer may feel he has contracted. The obvious solution to this problem of communication is to inform the employer, preferably at the time of contracting, that the physician's reports will cover only the information obtained at the time of the physical examination made at the employer's request. If this was not made clear to the employer at the time the physician and employer originally contracted for the pre-employment examinations, the physician would do well to clarify the arrangement at a later date, being careful, of course, to refrain from doing so in such a manner or at such a time that the employer would be likely to suspect that one particular employee had a serious health problem.

Another solution, more drastic than is really necessary, would be for the physician to exclude from the list of those on whom he would make pre-employment physical examinations, all persons who had previously consulted him as patients. Such a solution is recommended only if the physician, in making such examinations, finds it difficult to conduct the examination as if he did not know what actually he does know from prior diagnosis or treatment.

REVIEW COPIES OF MOTHERS GUIDE TO DIAPER HYGIENE

"A Mothers Guide to Diaper Hygiene," introduced recently at the annual meeting of the American Academy of Pediatrics, is now available to physicians and others in the health field for distribution to mothers of diaper age babies.

The booklet, prepared by the Section on Medicine of the National Baby Care Council, is designed to help the mother prevent diaper rash through good diaper hygiene procedures. It discusses the known causes of diaper rash and what may be done to counteract them.

Physicians, nurses, health departments, hospitals and interested workers in the health field may obtain a complimentary review copy of "A Mothers Guide to Diaper Hygiene," by writing to the National Baby Care Council, 1913 Walnut Street, Philadelphia 3, Pa.

Special First Year Depreciation Allowance

You can write off up to $4,000 of the cost of business and professional property in the first year because of a new federal income tax law passed by Congress in 1958. In addition, you get your regular depreciation allowance the first year on the balance after this write-off.

The new law allows a 20% deduction in the year of purchase of new or used depreciable business assets, other than buildings and land improvements. You do not get any 20% write-off on any purchases in excess of $10,000 for a single taxpayer, or $20,000 for a taxpayer filing a joint return.

Suppose you buy a new item of equipment on January 2, 1959, costing $5,000 and that you file a joint return with your wife. You get an immediate deduction of $1,000. This equipment now has a basis for depreciation purposes of $4,000. Assuming it has a useful life of 10 years, you could get a regular first year's depreciation allowance of 20% of $4,000, or $800, if you use, for example, the 200% declining balance depreciation method. Thus, your total depreciation write-off in the first year is $1,800 of the total $5,000 purchase price.

If you are in a 50% federal tax bracket, this means that you have cut your net cash outlay for the equipment to $4,100.

You get the full 20% first year's write-off, regardless of when during the year you purchased the asset.

The law spells out certain technical rules:

1. The property must have a useful life of at least 6 years. This could mean that business automobiles are not eligibile for the write-off.
2. The property must be bought after 1957.
3. The write-off does not apply to so much of the basis of the new property as is a carry over of the basis of trade-ins. For example, assume the new equipment costs $5,000, but you pay $3,500 cash plus your old equipment, which had a basis to you of $750. Even though your new equipment has a depreciation basis of $4,250, the 20% write-off applies only to $3,500.

This special write-off applies only to federal income taxes. Wisconsin does not have a similar rule.

BLOOD GROUPING TEST FOR IDENTIFICATION

In an illegitimacy action, the trial court may order the mother, child, and alleged father to submit to one or more blood grouping tests to determine whether the defendant can be excluded as the father of the child. The tests may be ordered, however, only after it has been determined that the tests would be relevant to the prosecution by the mother or the defense by the alleged father.

The results of the test are admissible only to prove that the defendant is not the father. Results which show only that the defendant might be the father are not admissible. Such tests must be conducted by a duly qualified physician or physicians each of whom has specialized in the field of clinical pathology or who possess a certificate of qualification as a certified pathologist issued by the American Board of Pathology.

Whenever relevant in a civil action to determine the parentage or identity of any child, person, or corpse, the court must direct any party to the action and any person involved in the controversy to submit to one or more blood tests. The results of the tests constitute conclusive evidence where exclusion is established and are receivable as evidence, but only in cases where a definite exclusion is established.

Reference: Wisconsin Statutes, 1959, Sections 325.23 and 52.36.

What Every Doctor Should Know about Workmen's Compensation

INFORMATION about the Workmen's Compensation Act is news of direct interest to virtually every physician in Wisconsin, irrespective of his specialty or location.

The law applies to more than 70,000 employers who have three or more employees. Farmers are excluded. If any one of the more than one million employees covered by the act receives an injury or disease during the course of his employment, the law makes the employer liable to provide certain indemnities and to provide or pay for such medical attention as may be needed to bring about rehabilitation.

Five points of advice will aid every physician in dealing with Workmen's Comp.:

★ Have your name listed on the State Medical Society's Workmen's Compensation panels if you want to treat employees under Workmen's Compensation.

★ Learn how to estimate disability according to the standards set up by the Industrial Commission of Wisconsin. Other standards or schedules are fine for your own information, but only the Commission's standards are authoritative in Wisconsin.

★ Submit your reports promptly to the Commission. Delay may mean withholding of compensation to the injured employee and professional fees to the physician. Quite often the unexpected misfortune places the employee in urgent need of compensation.

★ Fill out the report forms carefully, completely. Learn the terminology of the statutes concerning compensable employment disability.

★ Don't be afraid to ask questions. Contact either the State Medical Society, Box 1109, Madison 1, Wisconsin, or Mr. R. E. Gintz, Director of Workmen's Compensation, State Office Building, Madison 3, Wisconsin.

The following article provides answers to the questions most commonly asked of the State Medical Society in its past 24 years of experience with the Workmen's Compensation Act.

Q. Since the Workmen's Compensation Act is designed to provide protection to the working men of Wisconsin, how does the physician get into the picture?

A. When a workman has, or thinks he has, an injury or disease resulting from his employment, a report from the employer or a claim by the workman is filed with the Industrial Commission. To establish this claim a medical report verifying and specifying the workman's injuries or diseases and the degree of disability is necessary. The Industrial Commission and the employer or insurance company use the doctor's disability report to help determine the amount of compensation. If it turns out that the employer is obligated to provide or pay for necessary medical attention, he is required to supply the injured employee with "such medical-surgical and hospital treatment, medicines, medical and surgical supplies, crutches, artificial limbs and appliances. . . as may be reasonably required to cure and relieve the effects of the injury."

Q. How does the Industrial Commission determine whether the claim is justified?

A. Three essential elements must be ascertained before an award can be made to an injured claimant. They are an employer-employee relationship; the employer must be subject to the Act; and it must be proved that the injury or disease was suffered or acquired in the course of employment.

Q. Can any physician treat employees under the Workmen's Compensation Act?

A. Any licensed physician, as a general rule. The Workmen's Compensation Act requires the employer to maintain a "reasonable number" of competent and impartial physicians ready to undertake the treatment of his employees and to permit the employees to make a choice of their physicians from among them.

Prior to 1939 a great many companies had limited panels. However, during that year the State Medical Society of Wisconsin and the insurance companies selling workmen's compensation insurance in the state entered into a joint agreement to enlarge the panels through the voluntary cooperation of employers and the insurance companies. The object

was to give the workmen of Wisconsin an opportunity to secure virtual free choice of physician.

This agreement has come to be called the "Open Panel System." Any member of the State Medical Society of Wisconsin who indicates his willingness to serve injured employees may have his name included on the panel, which is prepared for each county in the state. These panels are certified to the insurance companies and are distributed to each employer of three or more persons in the state. This system has been so successful that more than 80% of the workmen in Wisconsin now have a wide choice of physicians.

Q. How does a doctor get on the panel?

A. About every three years the State Medical Society of Wisconsin circulates each of its members. The doctor is asked if he wants to be listed on the panel. If he completes the form and returns it promptly, he will automatically be listed on the next panel. However, a physician may at any time request listing or removal. The panels will not be changed until the next printing, but inquiries directed to the office of the Society will be answered on the basis of the current participation of each member.

Q. Does the doctor take on any obligations if he applies for a listing on the panel?

A. Yes. He agrees to have consultation when this is requested by the insurance carrier. He also agrees to communicate with the insurance carrier on the matter of choice of the consultant so that the consultant might be mutually agreed upon. Some exceptions will occur to these agreements, but the exceptions should be limited only to emergencies.

Q. Are any other practitioners listed on the "Open Panel"?

A. No. The State Medical Society panel lists only members of the State Medical Society. If any panel distributed by an insurance carrier contains the names of any other persons, it is not a panel approved by the State Medical Society.

Panels are distributed by another group of unlimited licensees, but these are not part of the State Medical Society program.

Q. What happens in the event of dispute or complaint about the handling of certain cases?

A. Under the "Open Panel" agreement a "State Conference Committee" is set up. It includes two representatives of the insurance carriers and two representatives of the State Medical Society. The duties of this committee are to mediate, if possible, cases where the insurance companies complain that the attending physician has neglected or refused to furnish the reports reasonably necessary, cases where insurance carriers are charged with having unreasonably interfered with what is properly in the discretion or control of the attending physician, and differences that may arise between the attending physician and the insurance carrier relative to remuneration; to review any situation in which it is claimed there is a violation of ethics; and to hear complaints relative to the competency of those serving on the panel and remove their names from it if an investigation shows that such complaints are justified. Cases involving medical ethics will be referred to the board of censors of the appropriate county medical society. Local committees may be designated to investigate and report back to the "State Conference Committee" with recommendations when it seems necessary. Mediation will be attempted only in cases in which the physician involved is on the listing provided by the State Medical Society.

Q. How is the physician paid for services rendered to an injured workman who is covered under the act?

A. Usually the employer or his Workmen's Compensation insurance company pays the physician. This is true where it is conceded that the injury was sustained on the job and that the treatment rendered was necessary because of such injury.

Where there is a dispute and it is found by the Industrial Commission that the case is not covered by the Workmen's Compensation Act, the employer is still liable for treatment authorized by him. On the other hand, the employee–patient is liable for unauthorized treatment. The Industrial Commission determines what treatment is covered under the Workmen's Compensation Act.

Q. What about other situations?

A. Where the employer fails to furnish a panel, the injured employee has complete free choice. Then the Industrial Commission has power to determine the reasonable necessity for treatment and the reasonable amount of the medical bill for which the employer is responsible.

Sometimes the employee does not give notice of his need for treatment, or he refuses to accept the panel physician. Then the employer has no liability and the Commission no jurisdiction to determine necessity or reasonableness.

Q. Are the claim reports filed by the physician kept confidential?

A. As a general rule communications from a patient to an attending physician are privileged. The Workmen's Compensation Act creates an exception to the law of privilege. The law provides that any physician attending a Workmen's Compensation claimant furnish to the employee, the employer, the Workmen's Compensation insurance carrier or the Commission information and reports relative to a compensation claim. The Commission explains that it is a practical necessity for physicians to be permitted to furnish information. Physicians will not be required to disclose confidential communications transmitted to them unless such information is

necessary to a proper disposition of the claim. The physician's testimony before the Commission should be absolutely fair, factual and unbiased.

Q. Does this mean that the physician need not divulge any information to the employer about an employee who files a claim?

A. The physician most certainly is not required to disclose information communicated to him by the employee when it goes beyond the information required for a proper disposition of a claim. However, under the Workmen's Compensation Act, the employer, the insurance company, or the Industrial Commission has the right to request a complete report on an injured employee. So, as a matter of fact, the physician may legally transmit to the employer such information as is required for a proper disposition of the claim. He is not privileged to release any other information than that ordinarily required for the handling of the claim.

Q. What is the doctor's role in disputed cases?

A. Naturally, there will sometimes be disputes between the employee and the employer or his compensation carrier as to whether the workman has suffered an injury in the course of his employment for which he is entitled to compensation. The physician may be asked to act as an expert witness for either the injured workman, the employer, or his insurance company. Of course, the physician may be involved because he was the attending physician. Therefore, doctors must be interested in the fact that the basis for any claim depends upon whether the injury or disease was suffered in the course of employment.

When the employer or his insurance company agrees to the fact that the injury or disease was suffered in the course of employment, the question then is confined to the extent of liability on the part of the employer. In many instances this means the physician must be prepared to explain the disability in terms of its effect on the employee.

Q. What about "outside" physicians appearing as expert witnesses?

A. Sometimes the injured workman calls upon a physician other than the attending physician to appear as an expert witness in his behalf. In such cases the physician must make a careful study and examination of the whole question and be prepared to present his opinion adequately and carefully. The Commission is authorized in the interest of a fair and impartial hearing to order examinations by physicians who are wholly independent of either the claimant, the employer, or the insurance carrier. Such physicians are witnesses of the State of Wisconsin at the time they appear to testify relative to the claim of the injured workman.

Q. How much is paid as a witness fee when physicians testify?

A. Ordinary witness fees are paid unless the physician performs work in preparation at the request of one of the parties to the dispute. In those cases in which the physician appears as an expert witness for the injured employee, and seeks to have his fees paid directly out of the compensation award, it must be expected that the Industrial Commission will endeavor to protect the employee through permitting only what it considers to be a reasonable allowance for the expert witness. Each bill necessarily depends on the circumstances of the individual case. The State Medical Society suggests to its members the practical necessity of submitting itemized statements substantiating the charges made by the expert witness. With an itemized statement before it, the Industrial Commission is in a better position to judge the work involved and the reasonableness of the charges of the physician.

Physicians must also keep in mind the fact that where an appearance as an expert witness is made for a claimant and no award is granted, they must look directly to the employee for payment. Likewise, where a physician treats an injured employee, and such treatment has not been authorized by the employer, and the Industrial Commission finds no liability on the part of the employer, the physician must look directly to his patient for payment.

Q. Must a physician obey a subpoena when only ordinary witness fees are paid?

A. Yes. Some physicians believe that they cannot be required to obey a subpoena unless an expert witness fee is paid to them. This is erroneous. Wisconsin courts have held that, except where there is a demand for preparation, every witness, expert or otherwise, must obey a subpoena upon payment of the ordinary witness fee.

Q. Are there special procedures for the handling of compensation claims of state employees?

A. In a sense, yes. The Commission is particularly explicit in its demands for itemized medical statements and for verification of the reasonableness of the medical charges in the case of state employees who file compensation claims.

Such cases require a report (on a form supplied by the Commission) from the attending physician, showing the nature of injury and the extent of disability. In addition, the physician and/or hospital must provide an itemized bill showing services rendered and charges made. This need not be verified.

In any case in which disability results or medical expense is involved, a statement is required from the employee (on a form supplied by the Industrial Commission) to the effect that he was injured in the course of his employment, reciting time and place of injury, the reasons for its occurrence, and the nature of injury, and stating all expenditures incurred for medical, surgical, and hospital treatment and medicines to the time of the claim, whether the claim is made for disability and, if so, what period of temporary disability and what permanent

disability is claimed, and what salary has been paid by the state during the period of disability. If bills have been paid by the injured, receipts are to be attached.

Further, these cases require a statement from the employing department stating whether injury occurred in the course of employment and whether treatment is believed necessary as claimed. This will be made in conjunction with the employee's statement and on the same form. If the department is unable to make a statement, the reason is to be stated.

Q. Can you explain non-schedule injuries?

A. Non-schedule injuries are those to some portion of the body other than the legs, arms, ears, or eyes, or their constituent parts. In other words, non-schedule injuries are to the torso or to the head, exclusive of eye and ear injuries.

Permanent disability for such injuries is estimated on the basis of the comparison between the nature of *the injury* and the nature of *an injury* causing permanent total disability of the entire body as a working unit.

Q. Now what is meant by schedule injuries?

A. Schedule injuries are estimated upon a different basis which bears no relation to wage loss. In these cases *the comparison is between the injured limb and a normal limb*, having in mind all of the useful functions of the limb or organ. Schedule injuries apply to arms, legs, eyes, and ears, as well as any constituent part of these members and organs. Disability is measured as a percentage loss of use as compared to amputation at a designated joint or joints or, in the case of the eye or ear, as a percentage loss of use compared to total loss of sight or hearing.

The estimate of disability has no reference to any particular occupational use to which the member is to be put. For example, the violin player who has lost a digit vital for the purpose of playing may consequently lose a great deal in wages. However, he receives exactly the same number of weeks compensation as does the laborer who may be able to perform his work nearly as efficiently as before even with the loss of a digit.

The law fixes the value of each finger, thumb, toe, hand, arm, foot, and leg at various joints. In the estimation of disability the physician takes into consideration the percentage of loss of function which has resulted to the given unit as of the joint at which disability exists. If disability is between joints, he considers the percentage of loss of function at the joint proximal to the point of disability. For example, if there is disability proximal to the wrist, but no disability above the elbow, the comparison is of the injured arm with a normal arm at the elbow or, put conversely, with an arm which has been amputated at the elbow.

In every case of schedule injury where there is a certain limitation of motion with no other element of disability involved, the functional disability is the same as in all identical cases. Therefore, the estimate in such cases should be uniform. If the employee has lost his ability to raise his arm at the shoulder beyond the horizontal level and has no other disability, the estimate should manifestly be the same in his case as in all other cases where the limitation of motion is identical and where no other disability has resulted. In case of schedule injuries the Commission has found it possible to establish by custom or rule the related disability applicable to a given handicap.

Q. Is there anything to help the physician in rating disabilities?

A. Yes. The Commission worked closely with the State Medical Society and physicians in establishing a schedule of related disabilities to serve as a guide in rating disabilities *short of amputations or total loss of all function.* In this guide, for example, where the loss of the function is represented by a limitation of active elevation of the arm in all directions to 90 degrees, but otherwise normal, *the loss is interpreted at 20% of the arm at the shoulder.*

Elements of disability include amputations, limitation of motion, pain, weakness, lack of endurance, and deformity. The disability is the percentage loss of use as compared to amputation at the affected joint or joints. When amputation is between joints, the loss is 100 per cent at the amputated joint, plus the percentage of bone loss at the next phalanx as determined by comparative x-rays. This is the loss for amputation and additional disability rating may be due for additional disability factors of the remaining portion of the limb. The Commission can determine the percentage of disability because of loss of motion from its guides, but the physician's opinion must be given as to the percentage of loss at each joint or joints that are affected for other elements of disability.

In all of the cases where landmarks have been adopted, the percentage of disability must vary as other conditions exist which constitute elements of functional loss. If, for example, in addition to limitation of motion, there is disabling pain and/or weakness, a percentage must be added for these elements. As the Commission has adopted these landmarks to measure disabilities only for loss of motion, the physician must exercise his best judgment as to the percentage to be added for other items which may conduce to disability. It should be clearly indicated at what joint or joints the disability is measured.

Q. What if the physician disagrees with these methods of estimating disability?

A. Most parties are in general agreement as to the essential justice of the current provisions. Obviously, the physician's methods of estimating must be in accordance with the law regardless of his personal feelings as to the correctness or justness of the law. Any feelings that the law is harsh, inadequate, or inequitable in certain individual cases

Industrial Commission Guide for Estimating Disabilities

The following guide represents per cent of loss of use as compared with amputations at involved joints. This guide measures disability for loss of motion only. Other factors of disability such as pain, weakness, loss of sensation, etc., are to be established separately.

Shoulder

Total ankylosis at the shoulder with arm at side, scapula fixed	75%
Total ankylosis at the shoulder with arm at side, scapula free	55%
Limitation of active elevation to 45° but otherwise normal	35%
Limitation of active elevation in all directions to 90° but otherwise normal	20%
Limitation of active elevation to 135° but otherwise normal	5%

Elbow

Ankylosis of elbow joint at 45° less than full extension (radio-ulnar motion destroyed, hand 45° less than fully pronated)	60%
Total ankylosis of arm at elbow at right angles	
With radio-ulnar motion intact	50%
With radio-ulnar motion destroyed (hand 45° less than fully pronated)	70%
Ankylosis of arm at elbow at 45° less than full extension with radio-ulnar motion intact	45%
Limitation of motion of elbow joint (radio-ulnar motion unaffected)	
Remaining range, 90°–135°	20%
Remaining range, 135°–180°	35%
Ankylosis of radius and ulna, estimated at elbow joint (hand 45° less than fully pronated)	20%

Wrist

Ankylosis, straight position	25%

Fingers

Complete ankylosis Thumb	Mid-position	Complete Extension
Distal joint only	25%	35%
Proximal joint only	15%	20%
Distal and proximal joints	35%	65%
Distal, proximal and carpometacarpal joints	85%	100%
Fingers		
Distal joint only	25%	35%
Middle joint only	75%	85%
Proximal joint only	40%	50%
Distal and middle joints	85%	100%
Distal, middle, and proximal joints	100%	100%

Fingers

Loss of Motion Fingers	Loss of flexion	Loss of use	Loss of extension	Loss of use
Distal joint only	10% =	1%	10% =	2%
	20% =	2%	20% =	4%
	30% =	3%	30% =	6%
	40% =	5%	40% =	8%
	50% =	10%	50% =	15%
	60% =	15%	60% =	20%
	70% =	20%	70% =	30%
	80% =	25%	80% =	40%
			100% =	60%
Middle joint only	10% =	5%	10% =	2½%
	20% =	10%	20% =	5%
	30% =	15%	30% =	10%
	40% =	25%	40% =	15%
	50% =	40%	50% =	30%
	60% =	50%	60% =	50%
	70% =	60%	70% =	70%
	80% =	70%	80% =	90%
			100% =	100%
Proximal joint only	10% =	5%	10% =	2½%
	20% =	10%	20% =	5%
	30% =	15%	30% =	15%
	40% =	20%	40% =	20%
	50% =	25%	50% =	25%
	60% =	30%	60% =	40%
	70% =	35%	70% =	75%
	80% =	40%	80% =	85%
			90% =	100%

(Where there is partial disability to two or more phalanges the estimate of the physician should take into consideration the greater cumulative effect because of such multiple disabilities. By analogy the allowances for complete ankylosis, where two or more joints are affected, may be used as a guide for comparison as to the greater allowance to be made because of the combined disabilities to two or more phalanges.)

Hip

Ankylosis in alignment for normal standing position	50%
Shortening of leg (no posterior or lateral angulation, age 50 or less)	
1 inch	7%
1½ inches	14%
2 inches	22%

Knee

Ankylosis at 170°	40%
Limitation of motion, remaining range 135°–180°	20%

Ankle

Ankylosis — favorable position 10°–15° equinus without loss of inversion and eversion	30%
Ankylosis—favorable position with loss of inversion and eversion	40%
Loss of inversion and eversion with full dorsi and plantar flexion remaining	15%

Physicians should submit their reports promptly to the Commission. Delay may mean withholding of compensation to the injured employee and of professional fees to the physician.

should never be allowed to influence the physician either in treating or in estimating disability.

Q. Should the doctor suggest the basis for settlement?

A. No. The physician who estimates disability should never concern himself with the result in number of weeks or in dollars. He should confine himself strictly to the medical field in estimating the disability on a functional basis. It is the function of the employer and the carrier, not that of the doctor, to propose the basis for settlement. The doctor's function is to report his factual findings with the probabilities and possibilities which may be involved, leaving to the employer or carrier the suggestion as to whether or not settlement should be made and upon what basis. Obviously, the physician should not be influenced by the amount of compensation which may be paid to the injured.

Q. Does the physician have any part in the computation of compensation?

A. Physicians should not attempt to compute the amount of compensation to become due. The law fixes the amount to be paid on the basis of disability which has resulted. This amount may be much greater or smaller than a particular physician might consider to be equitable. Computation of compensation based on estimates of disability is a function of the Industrial Commission. The attempts of physicians to compute sometimes result in erroneous figures and cause confusion and misunderstanding, both on the part of the physician and the injured person.

Q. In estimating disabilities in the schedule group, would 50% loss of motion mean 50% loss of function of the limb?

A. No, not necessarily. Loss of use and loss of motion are not identical. All functions of the limb, such as motion, freedom from pain, strength, coordination, quickness of action, endurance, sensation, and so forth, must be considered. The physician must assign to each factor the percentage which he considers represents the proportion of functional use of that factor as compared with all functions of a normal member. Also, to each factor must be applied the percentage of loss of motion of the particular factor which has resulted. The total of the resulting percentages constitutes the percentage of disability to the member involved.

When disability consists of loss of motion of a finger, the physician need not convert the degrees or percentage loss of flexion or extension into loss of use as shown by the guide on page 31, since the Commission can do this from the information supplied. The physician should clearly set forth the degrees or percentage loss of flexion and/or loss of extension at each joint of each finger that is affected. Normal extension is in a position of 180 degrees at all joints. Normal flexion at the distal joint of the finger is taken to be 70 degrees in the absence of any indication to the contrary. At the second or middle joint, normal flexion is considered to be 100 degrees and at the proximal 90 degrees. For example, a 30-degree loss of extension at the middle joint is 30% loss of extension rather than 16%, which many physicians often indicate. This is true because 30% loss of extension must be a percentage of the total motion of the joint, in this case the middle joint, which has only 100 degrees of motion.

Q. What kind of forms are used in reporting disabilities under the Compensation Act?

A. The Commission has adopted special forms for use of physicians. If the Commission is to pass upon a disability, it is necessary that the physician's report contain all of the information requested on this form as a basic minimum. If for some reason the form is not used by the physician, he should make certain that the requirements of the form are met. This will save returning the form to the physician with a request for supplementary report.

Q. If the physician completes the form properly, does this eliminate the need for him to personally appear in cases before the Commission?

A. Approximately 90% of all injury claims are paid by the employer or insurance company without dispute and on the basis of reports submitted. Where dispute arises and formal hearing becomes necessary, the Commission has a type of physician's report form which may eliminate the necessity of having the physician appear personally. The law provides that the contents of verified medical and surgical reports by physicians licensed in and practicing in Wisconsin presented by claimants for compensation shall constitute prima-facie evidence as to the matter contained therein, subject to such rules and such limitations as the Commission may prescribe. Likewise, reports of physicians and surgeons, wherever licensed and practicing, to whom the claimant has been sent for examination and treatment by the employer or insurer, are available for evidence provided the doctor consents to subject himself to cross-examination. The use of the form mentioned above makes it unnecessary for the physician to appear personally in some cases, especially where the issue and dispute is of a simple nature and it is desirable to avoid expense to the applicant in arranging for the personal appearance of the physician at the time of the hearing.

Q. Are special forms used in cases of loss of vision?

A. Yes. These forms will be supplied to physicians upon their request, along with rules for determining loss of visual efficiency caused by industrial injury.

Q. Are there any special forms for estimating loss of hearing?

A. In cooperation with the medical profession, insurance carriers, industry, and labor, the Commission has worked out formulas for determining the loss of hearing suffered during the course and as a result of particular employments. These formulas are a guide at the present time and are primarily for the assistance of the examining physician. Copies of the formulas and associated material may be obtained by writing the Commission.

Q. Are there any suggestions for completing the forms required by the Commission?

A. The Commission needs a full report covering all factors if it is to be able to fix the percentage of disability. Therefore, the doctor should set out in detail the elements which constitute disability. He should state as nearly as possible the weight and percentage of loss which has been ascribed to each. He should also set out his opinion as to the ultimate total percentage of disability which has resulted. This enables the Commission to check the report with its standards and to arrive at an intelligent and uniform conclusion.

Q. What about terminology?

A. Many reports have to be returned to physicians because of use of terminology which does not follow that set out in the statute. For example, the statute refers to the thumb, index, middle, ring and little fingers, and to disability at the distal, second, and proximal joints. Some physicians refer to the first, second, third, and fourth fingers, and some designate the thumb as the first finger. Some physicians speak of the interphalangeal joints, and sometimes of the first, second, and third joints, leaving confusion as to the point of measurement. If physicians will use the language of the statute, a good deal of confusion and necessity for supplementary reports can be avoided.

Q. Can a physician use his own standard for measurement of disability?

A. No standards or schedules not adopted by the Commission have the approval of the Commission. Only those adopted and published by the Commission itself should be considered as authoritative or as representing the Commission's thought as to percentages of disability based on certain functional losses. Obviously, physicians will have various ideas as to standards and schedules for estimating disability. However, they should use these as a matter of interest. Their opinions should be based upon their own examination and analysis and by reference to the standards which the Commission has adopted.

Q. To whom should the physician furnish reports with regard to a compensation claim?

A. Regardless of any other statutory provisions, the law specifically provides that any physician attending a Workmen's Compensation claimant may furnish to the employee, employer, Workmen's Compensation insurance carrier, or the Commission information and reports relative to a compensation claim. It further provides that a physician from outside Wisconsin may testify in compensation proceedings if he is licensed for the place of his residence or practice.

Q. How does a physician get the needed report forms?

A. Simply write to the Industrial Commission, State Office Building, Madison 2, Wisconsin.

Q. Where can the physician go for additional help in handling compensation cases?

A. The Workmen's Compensation Act and its administration is necessarily highly technical. The panel physician will find it easier to deal with the employer, the insurance carrier, and the patient if he has a reasonable understanding of its operation. Both the office of the State Medical Society and the Industrial Commission stand ready to assist in solving some of the problems facing the physician who treats patients entitled to or claiming benefits under the act. Inquiries may be directed either to the State Medical Society, Box 1109, Madison 1, Wisconsin, or to Mr. R. E. Gintz, Director of Workmen's Compensation, State Office Building, Madison 2, Wisconsin.

PHYSICIANS EXEMPT FROM JURY DUTY

You don't have to serve as a juror unless you want to. All practicing physicians, surgeons, and dentists are exempt. This doesn't mean that you are disqualified from jury duty. The exemption is a personal privilege which you may claim or waive as you wish.

If you are called to act as a juryman and wish to take advantage of your exemption, appear in court when called and state the cause of your exemption to the presiding judge.

Reference: Section 255.02 (2), Wisconsin Statutes, 1959.

Ethical Practices in Reference to Workmen's Compensation and the "Open Panel Program"

(PREPARED BY CONFERENCE COMMITTEE ON OPEN PANELS)

THE State Medical Society and the Workmen's Compensation insurance carriers have for many years subscribed to the principles of the Open Panel, wherein any member of the State Medical Society who so expresses a desire may have his name, office address, and office telephone listed on panels prepared on a county basis and distributed to employers covered by the Workmen's Compensation Act.

To be so listed carries with it certain obligations, and likewise on the part of the insurance carrier there are certain obligations in reference to physician relationships. The industrial nurse, also, has obligations and ethics which must guide her in reference to interpretation of the program to injured employees.

To clarify certain points of possible misunderstanding, the Conference Committee on Open Panels is listing below certain principles which should be followed by all parties concerned with the medical aspects of the compensation program.

* * *

CONSULTATION: It is a basic principle of the Open Panel Program that consultation can be requested by either the attending physician, the insurance carrier, the employer, or the employee. It is essential that the request for consultation be known to the other parties immediately concerned. Also, the selection of the consultant should be **mutually acceptable to both the attending physician, and the insurance carrier or the employer.**

If the Attending Physician Seeks Consultation: The insurance carrier should be notified of such a request, and if the consultant requested is not acceptable to the insurance carrier, another consultant acceptable to both parties should be selected. Under no circumstances should the attending physician arrange consultation without proper notification and authorization unless an emergency exists.

If the Insurance Carrier Seeks Consultation: Proper notification should be given the attending physician, and preferably he should be given the names of alternate consultants from which he can select one agreeable to him. Under no circumstances is it ethical for the insurance carrier (or the employer) to call in a consultant until agreement is made with the attending physician. If the attending physician refuses consultation, it is proper for the insurance carrier to place the matter in the form of a grievance before the Conference Committee on Open Panels; and if cooperation is still denied, the physician refusing consultation can be removed from the panel.

Frequency of Consultation: If the attending physician requests consultation, it can be as frequent as the insurance carrier deems reasonable. If the insurance carrier requests consultation, it can be as frequent as desired, and the insurance carrier is responsible for the reasonable expense of such consultation.

Filing of Consultation Reports: Under any circumstances the consultant is duty bound to file identical reports with both the attending physician and the insurance carrier of the employer.

Consultation Does Not Mean "Taking Over The Case": A consultant is not to take over the care of the case, except by mutual understanding and agreement. The case remains that of the attending physician until discharged by him, unless voluntarily released to the consultant. A written release is recommended. See page 66 of the Wisconsin Medical Journal, January 1954, for recommended release form.

REPORTS: The filing of reports is a direct responsibility of any physician participating in the Workmen's Compensation Program. As a means of lessening the extent of paper work involved in required reporting, the Conference Committee on Open Panels has devised simplified report forms for the initial report, the progress report, and the final report. The majority of insurance carriers subscribing to the Open Panel are using these forms. If physicians are requested to fill out complicated report forms, the Conference Committee will try to have the insurance company requesting such information adopt the simplified forms.

The Industrial Commission A–16 Report: One additional form must be filled out by physicians participating in the compensation pro-

(Continued on page 65)

gram provided disability exceeds three weeks, or any permanent disability results. The prescribed form is A–16 of the Industrial Commission. The Commission requires this form in order to determine payments to the injured worker. Failure to supply it promptly means that compensation may be withheld by the employer or carrier and thus injustice may be done to the patient. It is the key report upon which basic responsibilities are determined and met under the Compensation Act. The form is filed with the employer or insurance carrier and by it transmitted to the Commission.

Payment for Reports: Occasionally physicians have suggested the advisability of being reimbursed for the preparation of reports for insurance companies and the Industrial Commission. It is the opinion of the Conference Committee on Open Panels that the following principles be applied:

Simplified Reports (First Report, Progress Report, Final Report): No charge.

A–16 Report to the Industrial Commission: No charge.

If special reports are requested, or the insurance carrier does not wish to use the recommended simplified reports and requires a rather extraordinary report, a separate charge (depending on the extent of the report) is proper.

* * *

COMPLAINTS: The Conference Committee on Open Panels was established to iron out any difficulties between participating physicians and insurance carriers in all matters concerning charges, alleged unethical practices, etc. However, the Conference Committee will not accept a case until efforts have been made, through local personal contact, to reach a satisfactory solution of the problem involved.

* * *

FREE CHOICE OF PHYSICIAN: It is improper for an industrial nurse, or any person responsible to management, to direct an injured employee to a specific physician for care. If the injured patient asks for recommendations, a list of at least three physicians should be given, and the choice should be left entirely to the patient. When the Open Panel is used, every effort should be made to retain the relationship between injured worker and his family physician. If his injury is of a specialized nature which suggests need for consultation, such arrangements can be made as suggested above. If the injury is in the eye and a selection of physicians restricting their practice to this field alone is available, such information should be given the patient by referring him to the panel listing under the heading of "Eye, Ear, Nose and Throat." The industrial nurse must do her utmost to retain the good will of all physicians whose patients are employed in the plant. To do this she must bend every effort to maintain the philosophy of "free choice" of medical care for the injured employee.

CHANGING PHYSICIANS: The Compensation Act provides not only that the employee shall have the right to make choice of an attending physician from a panel but that he shall, if he wishes, have the right to make a second choice of physician from the panel upon request. If that is done there should be no hesitancy on the part of the first physician chosen to relinquish the right further to treat, but also there should be full cooperation with the second physician chosen in order to afford him full access to history and treatment already rendered, so that the second physician chosen under the statutory requirement may not be embarrassed as to his treatment of the employee. The law further provides that upon summary hearing the Commission may permit an employee to select a physician not on the panel.

Although these provisions are rarely invoked, they are implicit in the Compensation Act and should be fully recognized and followed when request is made by an employee.

CAN YOU PRACTICE WITHOUT A LICENSE?

Suppose you are just out of military service. Or you have just arrived in Wisconsin from another state. Dare you practice, either on a temporary or permanent basis, before you get your license?

Suppose you enter practice in association with one or more other physicians. May you practice before your licensing is complete?

Be careful! Your good intentions may be illegal practice. You may be subject to sharp criticism, or worse.

The best advice: Postpone any contact with patients until your Wisconsin licensure is complete.

The next best advice: Be circumspect. Issue no prescriptions over your own signature. See patients only in consultation with your associates who are already licensed. Act only as an apprentice or as a physician's deputy, never as a privately practicing physician.

Reference: Section 147.15 (2), Wisconsin Statutes, 1959.

A Record of Value to You and Your Patients

The Study Committee of the Maternal Mortality Survey of the State Medical Society has devised for pregnant patients a record form which is highly recommended for use in the physician's office and also as a record kept in the hospital during the last month of pregnancy with any notations as to special care which might be required if the patient is brought to the hospital and delivery is precipitous, before the attending physician can arrive.

If you are not acquainted with the form, it is suggested that you write for a sample sheet; and if found suitable for your practice, that you order a supply and use the forms as recommended. It is felt by the Study Committee that use of the forms may help to meet some emergency problems and avoid complications which may result in patient demise.

T. A. Leonard, M.D.
Chairman, Study Committee
Maternal Mortality Survey

Prenatal Facts

SUGGESTED PROCEDURE } File at hospital in last month of pregnancy. If there are indications of possible premature delivery file earlier. Direct this form to the supervisor of obstetrics of the hospital to which the patient will be admitted.

Name ---------- Address ---------- igion ----------
Expected date of confinement ---------- -- Para--------
Number of abortions---------- miscarriage- del.----------
multiple birt'
Natu-- ----------
Weig
Speci ----------
------ ----------
Chest
Evaluati --------
Wasserma --------
Coombs te: ------
Date of visi
Weight
Heart

FOR YOUR CONVENIENCE, DOCTOR . . .

The Division on Maternal and Child Welfare has prepared a sheet which is recommended for use by all Wisconsin physicians in reference to hospital care of obstetrical patients . . .

You will find this of convenience to you, and of much value to your obstetrical patients. It will alert the hospital to proper care when your patient is admitted for delivery.

Per pad of 100 forms—$2.00.

Write:
Division on Maternal and Child Welfare
State Medical Society of Wisconsin
Box 1109, Madison 1, Wisconsin

YOUR DEADLINES AND OTHER "MUSTS"

Below are some of the deadlines and "musts" of a practicing physician:

Taxes

1. By January 15, 1961, you must pay the final installment of the estimated federal tax on your 1960 income. This may necessitate an amended declaration by that date if you find that you underestimated 1960 income. A final income tax return for 1960, filed before January 31, 1961, will be treated as the equivalent of an amended declaration as of January 15. Penalties are assessed for certain underestimating of taxes. These penalties and their legal avoidance are discussed in Section 5 below.
2. By January 31, you must:
   (1) File the employer's final return of income taxes withheld in 1960 on Form W–3.
   (2) Furnish a statement to employees on Form W–2 showing wages paid and amount of tax withheld during the calendar year 1960.
   (3) File fourth quarterly return for 1960 of income and social security tax withheld on wages paid employees on Form 941 if:
      (a) The entire tax was not paid by timely depositary receipts for all three months of the preceding quarter; or
      (b) Less than $100 was withheld in each of the months of October, November, and December, 1960.
   (4) Pay income and social security taxes withheld on 1960 wages of employees if:
      (a) More than $100 was withheld in December, 1960, and not paid to government depositary earlier in January, 1961; or
      (b) Less than $100 was withheld in each of the months of October, November, and December, 1960.
3. Miscellaneous:
   (1) If the total of income and social security tax withheld on employees' wages exceeds $100 a month in each of the three months of the preceding calendar quarter, and payments were made to a government depositary previous to the fifteenth of the next month, the quarterly return on Form 941 should be filed on or before the tenth of February, May, August, and November, as the case may be.
   (2) If instructions contained in paragraphs (3) and (4) of Section 2 preceding are applicable to your situation, make similar quarterly payments and returns on April 30, July 31, and October 31, 1961, for the respective preceding calendar quarters.
   (3) If income and social security taxes withheld on employees' wages exceed $100 in either the first or second months of each calendar quarter, the amount thereof should be paid to a government depositary by the fifteenth of the following month. The amount of such withheld taxes for the last month of each quarter may either be paid to a government depositary by the fifteenth of the month immediately following or may accompany the quarterly return if the latter is filed by the end of the month following such calendar quarter.
4. File your Wisconsin and federal partnership and personal income tax returns as early in 1961 as possible, but no later than April 15. State returns should be filed with the assessor of incomes in the district in which you live, Federal returns with the Director of Internal Revenue, Milwaukee.
5. Estimates of Income; Quarterly Adjustments; Penalties.

   The first quarterly estimate of your 1960 income must be shown on a federal declaration form which has to be filed, together with the estimated tax due, by April 15, 1961. Other installments of the tax are due, together with amendments in the declaration should there be a change upward or downward, by June 15, and September 15, 1961. As to the final payment or amendment of declaration due in January, 1962, follow the alternative procedure described in Section 1 above.

Excluding cases of willful understatement, interest penalties are provided for underestimating and thus underpaying taxes on declaration of estimated income, to the extent that each quarterly installment is under 70 per cent of one-fourth of the tax due for the year, as shown on the filed return. A penalty of 6 per cent computed on the amount of the underpayment from the due date of a particular installment is added to the tax. The penalty can be legally avoided in either of two ways. The first is to base the estimated tax upon the previous year's income at 1961 tax rates and exemptions in force at the time a particular installment is being paid, or to base quarterly payments on the previous year's tax, whichever is the lesser. The second is to follow the so-called "90 per cent rule." This is a rather complicated formula, and each physician who cares to follow it should consult his attorney or tax accountant.

Annual Registration in Wisconsin

1. Register with the Secretary of the Wisconsin State Board of Medical Examiners, Room 1140, State Office Building, 1 West Wilson Street, Madison 3, in the month of January. This registration will be on a form furnished by the Board of Medical Examiners.

Annual Narcotics Registration

1. Register with the Bureau of Internal Revenue, Milwaukee, as required by the federal narcotics law, and pay the annual tax of $1.00 *before* July 1, 1961. You are subject to penalties for overlooking either the registration or the tax.

Change of Residence:

1. Notify the Director of Internal Revenue, Milwaukee, Wisconsin, to insure the legality of your narcotics license. Penalties are imposed for failure to do this.

Remember to:

1. Make prompt report to the State Board of Health, State Office Building, 1 West Wilson Street, Madison 3, of cancer cases, communicable diseases and others.
2. File with the city health officer or county register of deeds a certificate for all births attended by you within five days of the event. Otherwise your medical fees are unlawful. Sec. 69.30 (1), Wis. Statutes.
3. Register with the county judge if you desire reference work on commitment proceedings for persons alleged to be mentally ill, mentally infirm, mentally deficient, inebriate, or drug addicts.
4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician, or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), Wis. Statutes.
5. Report *immediately* the following deaths, as required by Section 966.20, Wis. Statutes, to the sheriff, police chief, or coroner of the county in which such death occurred:
   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.
   e. All deaths due to poisoning, whether homicidal, suicidal, or accidental.
   f. All deaths following accidents, whether the injury is or is not the primary cause of death.
   g. When there is no physician in attendance.
   h. When a physician refuses to sign the death certificate.

Federal and Wisconsin Unemployment Compensation Liability.

See in this connection the text of the box on page 47 of this issue.

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, by-laws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, by-laws and regulations of the state society.

148.03 (1) Nonprofit plans for sickness care. The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(2) Such plans shall be governed by the provisions of s. 200.26 and by no other law relating to insurance unless such law is referred to in s. 200.26 and no law hereinafter enacted shall apply to such plans unless they are expressly designated therein or refer to such organizations as are responsible for the operation of such plans.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and Bylaws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

SEC. 3. Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the perquisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member, providing that the member continues in good standing in his local county medical society.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the Bylaws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors and the immediate past president. The president, the president-elect, the secretary, the treasurer and the speaker of the House of Delegates shall be ex officio members of the Council, but without the right to vote. Nine of its members shall constitute a quorum.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

* As amended by the 1960 House of Delegates.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

SEC. 2. The officers, except the councilors, shall be elected annually. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a bylaw, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the Bylaws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. The Council shall establish rules relating to requiring written papers of speakers. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each fifty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

The term "full-paid members," as used in this section, includes regular members of the Society,

life members, affiliate members, associate members, educational members, and members whose dues are waived or remitted by official action of the Society. Special service members, resident members, partial-pay members, and members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society* by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society thirty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

* Chapter XI, Section 8 was revised in 1958 to require reporting of delegates by the end of the calendar year. This section editorially revised to conform with 1958 amendment.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its mem-

bers as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and bylaws, together with any amendments to the same.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

SEC. 7. The Council, as the executive body of the House, may devise an oath of office and have it administered through its Chairman to each constitutional officer and to each Councilor at an appropriate time and with an appropriate ceremony, upon their assuming office, such oath to state that each such officer and Councilor shall abide by and conduct his office in all respects in conformity with the Constitution and Bylaws of the Society and the decisions of its House and Council.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet on the day preceding the annual session, and daily *if necessary* during the session and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and

shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer. The Council may elect a vice chairman and create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities.

SEC. 7. The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

- A Commission on Scientific Medicine
- A Commission on Public Relations and Communications
- A Committee on Public Policy.
- A Committee on Grievances.
- A Commission on Hospital Relations and Medical Education.
- A Committee Advisory to the Woman's Auxiliary.
- A Committee on Cancer.

Unless otherwise provided in these Bylaws, each of these committees shall consist of five members, each of whom shall serve for a term of five years. One member of each of these committees shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee the original appointments shall be for terms of one, two, three, four, and five years, and thereafter for terms of five years each.

SEC. 2. The Commission on Scientific Medicine shall consist of five *appointed* members and the deans of the two medical schools in Wisconsin and the medical editor of the Wisconsin Medical Journal. Each appointed member shall serve for a period of five years. The Commission on Scientific Medicine shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

SEC. 3. The Commission on Public Relations and Communications shall consist of nine members appointed by the President of the Society. Appointments shall be so made that the terms of one-third of the members expire each year. The Commission on Public Relations and Communications shall study, make recommendations, and implement approved activities to improve the distribution of medical service to the public. It shall also be responsible for all matters relating to industrial, rural health and safety. The Commission shall direct the public information and health education programs of the Society and shall assist the component societies in the conduct of similar programs. It shall also conduct an internal professional relations program to encourage active participation of all members in the affairs of the Society.

SEC. 4. The Committee on Public Policy shall consist of seven members, and the president, the president-elect and secretary. The committee shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

SEC. 5. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice. The committee shall possess similar responsibilities where request is made to investigate complaints bearing upon a member's alleged violation of any provision of the Medical Practice Act.

The committee shall consist of nine members and the terms of one-third of its members shall expire each year, with each member appointed for a term of three years.

SEC. 6. The Commission on Hospital Relations and Medical Education shall consist of nine members, to be appointed by the President, with confirmation by the House of Delegates. As nearly as possible the terms of one-third of the members shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three-year terms.

Its duties shall include the subjects of medical education, the interrelationships of the medical profession to hospital institutions, and all matters pertaining to the general subject of hospitals and the ability of the medical profession to provide quality medical care through their facilities.

The Commission shall be responsible to the Council in the interim between sessions of the House of Delegates, and the Council may assign one or more of its members to serve as liaison between the Council and the Commission.

SEC. 7. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president,

the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 8. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 9. The Wisconsin Medical Journal shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted on payment of $10 annual dues.

SEC. 5. *Educational Memberships:* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

SEC. 6. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 7. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and Bylaws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and bylaws shall have been submitted to the Council and received its approval.

SEC. 2. Only one component medical society shall be chartered in each county.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a bona-fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and bylaws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may pro-

vide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the society.

A member of a component society whose license has been revoked or suspended shall be dropped from membership automatically as of the date of revocation or suspension. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. Each component county society shall elect one or more delegates and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these Bylaws. The term of office shall be pursuant to the constitution and bylaws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

SEC. 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and bylaws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member until the month following his discharge from the armed forces of the United States, at which time he shall pay prorated dues for the balance of the calendar year of his discharge from service. Special service membership shall lapse at the close of the calendar year of the discharge of each such member from service.

CHAPTER XII

SECTION ON MEDICAL HISTORY

Membership in this Section shall be composed of those interested in preserving medical history in Wisconsin. The Section shall have the power to elect its chairman and other officers, and the office of the secretary of the State Medical Society shall provide secretarial assistance to it.

Annual dues shall be fixed by the Section and shall not exceed $10 per year. The Section is empowered to accept contributions to its projects and may solicit funds in behalf of the Society. All funds of the Section shall be segregated, and ex-

penditures from them shall be made under direction and supervision of the Section, subject to approval of the Council.

Special membership certificates may be issued to those who become members of the Section, and displays may be developed by the Section for exhibit at the Society's Annual Meeting and elsewhere.

CHAPTER XIII
SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIV

SECTION 1. These Bylaws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these Bylaws, all previous Constitutions and Bylaws are thereby repealed.

SPECIALISTS AND GENERAL PRACTITIONERS

Available through Placement Service

The Placement Service of the State Medical Society has registered with it a number of specialists in various fields as well as general practitioners. Contact the Placement Service by writing Box 1109, Madison, Wisconsin.

SALE OF CONTRACEPTIVES AND ABORTIFACIENTS

The sale of contraceptives and abortifacients or articles appropriate to that use and sold with the intention that they be so used, is prohibited by Section 151.15 of the Wisconsin Statutes to all persons other than a physician or pharmacist duly licensed in this state. In no event may such article, drug, or preparation be sold to any unmarried person.

Prohibited also is the advertising or displaying of such articles for sale, or the manufacture, purchase or possession of a machine or device appropriate for vending contraceptives or abortifacients.

Violation of the provisions of this statute subjects the violator to a fine of one hundred dollars to five hundred dollars ($100 to $500), or imprisonment in a county jail not to exceed six months, or both.

Reference: Wisconsin Statutes, 1959, Section 151.15.

PRINCIPLES OF MEDICAL ETHICS of the AMERICAN MEDICAL ASSOCIATION

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Adopted June 7, 1957

The "Home" of the State Medical Society on the south shore of Lake Monona houses the Wisconsin Medical Journal, the Society's Blue Shield plan, general administrative offices, dining room, and Council room. Nearly 200 committee and other meetings are held here annually.

STATE MEDICAL SOCIETY OF WISCONSIN

330 EAST LAKESIDE STREET

MADISON 5, WISCONSIN

Services to Members

The Wisconsin Medical Journal
Life Insurance
Disability Income Protection
WPS Protection
Open Panel Program under Workmen's Compensation
Postgraduate Education Programs

Physician Placement
Medico–Legal Consultation
Public Relations
Legislative Representation
Governmental Agency Contacts
Medical Economic Advice

Health Educational Activities
Voluntary Health Agency Contacts
Medical Student Loans
Grievance Services
Museum of Medical Progress
Executive Office Services

Members, State Medical Society of Wisconsin*

Adams:
Weihe, A. R.

Adell:
Bemis, I. M.
Naylen, F. J.

Albany:
Bongiorno, F. J.

Algoma:
Hopkins, R. G.
March, J. F.
Pudleiner, H. G.
Stiehl, C. W.

Allenton:
Fisher, R. S.

Alma:
Bachhuber, M. O.

Amery:
Arneson, O. N.
Byrne, W. R.
Cornwall, W. B.
Dasler, H. A.
Ford, K. K.
Marra, M. G.
Whitlark, F. L.

Amherst:
Osicka, S. R.

Antigo:
Beattie, B. W.
Cromer, R. W.
Curran, W. P.
Dorzeski, E. F.
Garbisch, F. H.
Garritty, J. E.
Lambert, J. W.
McKenna, E. A.
Moore, G. E.
Seilin, Josef

Appleton:
Adrians, W. A.
Anderson, J. G.
Benton, J. L.
Bolton, E. L.
Bonner, J. N.
Bravick, D. D.
Brei, F. A.
Carlson, G. W.
Chandler, W. W.
Claypool, Blaine, Jr.
Cunningham, P. M.
Curry, J. C.
Dafoe, W. A.
Danford, H. G.
DeCock, R. D.
Engstrom, D. P.
Erchul, J. W.
Frawley, W. J.
French, G. A.
Gallaher, D. M., Jr.
Giffin, W. S.
Gmeiner, J. E.
Green, C. J.
Gross, H. T.
Hale, William H.
Hamel, H. H.
Harrington, Wm. J.
Hauch, F. M.
Haza, B. J.
Hegner, G. T.
Huberty, F. J.
Kagen, M. S.
Keane, K. M.
Kennedy, R. O.
Konz, S. A.
Krueger, E. N.
Laird, J. W.
Landis, R. V.
Loescher, T. M.
Luther, T. W.
MacLaren, J. B.
Marshall, F. S.
Marshall, V. F.
McCanna, P. R.
Meighan, P. P.
Meyers, C. L.
Mielke, E. F.
Miller, E. J.
Neidhold, C. D.
Nichols, G. P.
Park, R. K.
Petersen, G. J.
Raney, E. H.
Rankin, F. J.
Russell, J. H.
Savage, G. W.
Siegrist, K. J.
Simenson, R. S.
Swanton, M. E.
Taylor, A. C.
Veum, J. S.
Weissler, J. B.
Williams, L. P.
Wright, Frank, Jr.
Young, J. J.
Zeiss, E. J.

Arcadia:
Comstock, Elizabeth
Weber, F. T.

Argyle:
Hunter, R. E.

Arpin:
Ryan, C. J.

Ashland:
Bargholtz, W. E.
Grand, C. A.
Grigsby, R. O.
Jauquet, J. M.
Kreher, J. E.
Larson, H. H.
Merrill, W. G.
Prentice, B. C.
Prentice, J. W.
Sandin, H. V.
Smiles, W. J.
Stanley, R. A.
Tucker, W. J.
Weeks, F. D.

Athens:
Martens, T. J.

Augusta:
Moland, O. G.
Thieda, E. S.

Avoca:
Reynolds, Bertha E.

Bailey's Harbor:
Fillbach, H. E.

Baldwin:
Olson, C. A.
Sargeant, G. M.
Torkelson, L. B.

Balsam Lake:
Burdette, Stella I.

Bangor:
Ruppenthal, K. P.

Baraboo:
Edwards, A. C.
Hannan, K. D. L.
Huth, M. F.
Pearson, C. R.
Pischke, E. F.
Siebert, J. T.

Barron:
Macmillan, D. G.
Saydjari, M. S.
Strang, C. J.
Whaley, R. C.

Bayfield:
Moody, L. W.

Bear Creek:
Morneau, L. F.

Beaver Dam:
Bayley, H. G., Jr.
Bender, R. I.
Bergen, P. M.
Boock, R. F.
Cook, R. S.
Corso, Xavier
Davis, T. C., Jr.
Drescher, G. G.
Erickson, N. W.
Funcke, Wm. E.
Hoyer, E. C.
Kores, A. B.
Qualls, C. L.
Richards, W. G.
Roberts, R. R.
Szweda, J. A.
Taake, E. R.
Urbanek, R. E.
Vrabec, A. P.
Way, R. W.
Welsch, J. M.

Belgium:
Dorr, R. H.

Belleville:
Donlin, W. F.

Beloit:
Allen, W. J.
Babb, J. L.
Baldwin, R. M.
Beltran, J. C.
Brillman, L. P.
Carney, C. M.
Carter, K. L.
Chancey, R. L.
Clark, D. M.
Cochrane, W. L.
Crockett, W. W.
Fitzgerald, W. M.
Flarity, T. H.
Freeman, W. S.
Glesne, O. G.
Gunderson, R. H.
Johnson, F. K.
Jones, E. T.
Kasten, H. E.
Kishpaugh, H. W.
Kleppe, L. W.
Lakritz, L. W.
Lang, T. J.
Matthews, G. C.
Mauermann, W. J.
Ottow, A. F.
Pollard, W. H., Jr.
Pruett, W. A.
Raube, H A.
Sanderson, R. J.
Scholten, W. A., Jr.
Springberg, J. C.
Thayer, R. A.
Thomson, G. H.
Tuftee, A. O.
Twyman, A. H.
Wilson, R. F.

Berlin:
Koch, H. C.
Koch, J. C.
Seward, L. J.
Sievers, D. J.
Stone, G. C.
Taugher, V. J.

Big Bend:
Raschbacher, J. L.

Birnamwood:
Damp, O. E.

Black River Falls:
Holder, R. L.
Krohn, J. I.
Krohn, Robert
Marks, J. R.
Noble, J. H.
Thurow, R. M.

Blair:
Schneider, O. M.

Blanchardville:
Unterholzner, L. J.

Bloomer:
Asplund, M. W.
Clauson, C. T.
Hudek, D. F.
Murphy, P. W.

Bloomington:
Edwards, P. K.

Bonduel:
Grover, W. W., Jr.
Stuff, Patricia J.

Boscobel:
Freymiller, E. F.
McNamee, J. R.
Mueller, C. E.
Randall, E. M.

Boyd:
Sallis, D. A.

Brandon:
Lautenbach, E. T.

Brillion:
Barajas, R.

Brodhead:
Hein, W. E.
Stuessy, M. W.

Brookfield:
Benoit, M. P.
Childers, G. A.
Davis, J. B.
Lubitz, J. M.
Nothum, J. P.
Roth, D. A.
Reuhl, R. L.
Stoklos, Michael
Teresi, J. L.
Werts, K. G.

Brownsville:
Friedrich, L. E.
Raymond, R. G.
Ries, M. F.

Bruce:
Whalen, M. L.

Burlington:
Baker, D. J.
Erickson, L. W.
Granzeau, H. W.
Krismer, G. J.
Mastallr, L. O.
McNeel, Laird
Sroka, Wm. C.
Van Liere, J. D.
Wheaton, R. C.

Butler:
Schoeneman, R. H.

Butternut:
Boldt, R. E.

Cadott:
Bowe, C. T.
Haines, B. J.
Zenner, C. E.

* As of December 15, 1960.

Cambria:
Brown, J. G.

Cambridge:
Amundson, K. K.
Nemec, George, Jr.
Nora, J. J.

Campbellsport:
Graves, R. H.
Hoffmann, L. A.

Casco:
Kerscher, E. J.

Cashton:
Mauel, N. M.

Cassville:
David, J. J.

Cedarburg:
Blanchard, P. B.
Hurth, O. W.
Katz, H. J.
Kippenhan, J. E.
Misch, Allen

Cedar Grove:
Jensen, J. S.

Chetek:
Adams, R. W.

Chilton:
Humke, E. W.
Humke, K. R.
Knauf, J. W.
Knauf, N. J.

Chippewa Falls:
Brown, F. J.
Graber, R. E.
Hatleberg, C. B.
Hatleberg, E. A.
Henske, W. C.
Janc, W. F.
Kemper, C. A.
Picotte, L. W.
Rahn, B. F.
Sazama, F. B.
Sazama, J. J.
Shonat, G. C.

Clear Lake:
Campbell, L. A., Jr.

Clinton:
Minter, D. L.
Thomas, W. O.

Clintonville:
Arnold, W. G.
Auld, Irving
Bate, L. C.
Caskey, H. S.
Larson, Owen E.
Topp, C. A.

Cochrane:
Meili, E. A.

Colby:
Hansen, R. L.
Koch, James W.

Coleman:
Graner, L. H.

Colfax:
Felland, O. M.

Columbus:
Cheli, C. F.
Poser, J. F.
Poser, R. F.
Shearer C. E.
Shearer, T. M.

Cornell:
Hendrickson, R. L.

Crandon:
Moffet, D. V.
Rathert, Burton S.

Cross Plains:
Lappley, W. F.
McEnroe, J. E.

Cuba City:
King, C. S.
Rosmann, H. K.
Taylor, H. W., Jr.
Terry, R. E.

Cudaby:
Ackerman, D. S.
Ackerman, E. J.
Fine, J. M.
Homsey, J. J.
Kash, S. H.
Lando, D. H., Jr.
Landsberg, Manfred
Latorraca, Rocco
Malone, J. A.
Marcich, Z. P.
Pizer, J. A.
Rosenbaum, M. K.

Cumberland:
Anderson, R. M.
Jirsa, H. O.
Lund, R. E.
Lund, S. O.
Thompson, R. C.

Darien:
Truax, G. O., Jr.

Darlington:
McConnell, E. D.
McGreane, N. A.
Oertley, Robert E.
Olson, Lyle L.
Ruf, D. F.

Deerfield:
Ingwell, C. L.

De Forest:
Grinde, J. M.

Delafield:
Olsen, L. C. J.

Delavan:
Crowe, N. F.
Galgano, R. S.
Levin, H. M.
Martin, J. E., Jr.
O'Keefe, F. L.
Smiley, G. A.
Werbel, H. J.
Woods, Wm. C.

Denmark:
Hering, G. V.
Michna, C. T.

De Pere:
Elders, W. F.
Merline, G. B.
Waldkirch, B. P.
Waldkirch, R. M.

De Soto:
Bolstad, H. A.

Dodgeville:
Buckner, H. M.
Hamilton, W. P.
Morton, H. H.
Rasmussen, N. G.

Dousman:
Watry, T. D.

Durand:
Blose, Irvin L.
Bryant, R. J.
Springer, J. P.

Eagle:
Nothum, J. P.

Eagle River:
Colgan, J. J.
Jacobson, L. L.
Oldfield, R. A. A.

East Ellsworth:
Klaas, F. B.

East Troy:
Kohn, Louis

Eau Claire:
Aitken, H. M.
Anderson, F. G.
Aronson, Willard
Bates, P. J.
Beebe, G. W.
Bjurstrom, R. O.
Blom, Julius
Brousseau, E. R.
Brown, R. C.
Buckley, R. A.
Cameron, W. G.
Carlson, S. D.
Conlon, H. J.
Derge, H. F.
Dibble, J. B.
Falstad, C. H.
Fink, R. J.
Finucane, P. J.
Frank, R. C.
Fuson, H. S.
Gericke, J. T., Jr.
German, K. L.
Giffen, G. G.
Griffith, D. R.
Haag, A. F.
Henke, S. L.
Hilker, A. W.
Hoff, D. E.
Hudson, R. F.
Huston, H. C.
Ihle, C. M.
Kennedy, R. L.
Kilkenny, T. E.
Kinsman, F. C.
Klein, A. J.
Kundert, Elizabeth
Lindquist, M. F.
Lorenz, A. A.
Lotz, R. M.
Lowe, J. W.
Manz, W. R.
Martins, J. K.
Mautz, W. T.
McAfee, G. D.
Midelfart, Peter A. H.
Miller, G. E.
Moberg, T. D.
Nester, H. D.
Nezworski, L. G.
Paulson, W. O.
Richards, R. R.
Russell, S. B.
Sorensen, H. E.
Spelbring, P. G.
Strand, R. C.
Thimke, H. E.
Wahl, G. E.
Walter, K. E.
Willison, D. M.
Wishart, J. H.
Ziegler, J. E. B.

Edgar:
Schulz, H. A.

Edgerton:
Boulet, W. J.
Burpee, G. F.
Cohen, D. A.
Falk, V. S., Jr.
Sumner, W. C.

Elcho:
Dailey, D. W.
Dailey, P. J.

Elkhart Lake:
Heiden, H. H.
Martineau, J. E.

Elkhorn:
Bill, K. C.
Helmbrecht, M. G.
Mol, H. R.
Rawlins, J. A.
Rogers, R. J.
Sorenson, E. D.
Stuessy, M. F.

Ellsworth:
Aanes, A. R.

Elm Grove:
Berridge, F. E., Jr.
Blake, W. J.
Erwin, C. J.
Erwin, C. P.
Grade, J. O.
McCormick, G. E.
Myers, S. C.
Redlin, R. R.
Schmidt, E. A.
Settiml, A. L.
Wisniewski, J. H.
Zurheide, H. J.
Zurheide, H. O.

Elmwood:
Springer, F. A.

Elroy:
Solberg, M. E.

Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Gray, Roger S.
Sorkin, S. S.

Fall Creek:
Zboralske, F. F.

Fennimore:
Bailey, M. A.
Howell, E. C.
Shields, C. H., Jr.

Fond du Lac:
Becker, N. O.
Bissegger, Arnold
Borsack, K. K.
Carlovsky, R. E.
Cerny, F. J.
Charles, J. E.
Devine, H. A., Jr.
Fieber, W. W.
Flanagan, C. M.
Gardner, L. C.
Guth, H. K.
Hagel, Hans
Huebner, J. S.
Hutter, A. M.
Keenan, L. J.
Kendell, W. G.
Kief, H. J.
Koll, J. H.
Leonard, C. W.
Liewen, B. E.
Mauthe, Howard
McCormick, D. W.
McCullough, James C.
McCullough, John C.
McLane, Hugh J.
Meusel, H. H.
Myers, W. E.
Pallin, Josephine N.
Parrish, J. G., Jr.
Pawsat, E. H.
Peterson, C. R.
Schroeder, R. W.
Sharpe, H. R.
Sharpe, H. R., Jr.
Sharpe, J. J.
Smith, D. A.
Smith, E. V., Jr.
Steube, R. W.
Swan, J. C.
Theisen, S. A.
Twohig, D. J.
Twohig, D. J., Jr.
Vetter, E. W.
Vrtilek, M. R.
Waffle, R. L.
Waldschmidt, W. J.
Wier, J. S.
Wojta, W. C.
Yockey, J. C.

Footville:
Evenson, R. G.

Forestville:
Hirschboeck, J. G.

Ft. Atkinson:
Aufderhaar, H. W.
Gruesen, F. A.
Gueldner, L. H.
Hanson, O. H.
Harris, J. J.
Hunsader, H. N.
Mallow, H. G. E.
Maloney, C. G.
Notbohm, D. R.
Russell, J. C. H.
Venning, J. R.
Voytek, J. J.

Fox Lake:
Elliott, E. S.

Fox Point:
Peters, L. M.
Thompson, L. H.

Frederic:
Andrews, W. C.
Fischer, W. A.
Moore, R. M.

Fredonia:
Wallestad, P. W.

Fremont:
Haselow, J. R.

Galesville:
Alvarez, R. L.
Moen, C. B.
Rohde, E. P.

Genoa City:
Dekker, Cornelis

Gillett:
Daley, E. F.
Klutzow, F. W.

Glenwood City:
Limberg, A. W.
Limberg, P. W.
McCusker, C. F.

Grafton:
Pelant, K. F.
Seidl, J. A.

Grantsburg:
Cutshall, R. A.
Hartzell, R. L.

Green Bay:
Angus, D. C.
Austin, S. D.
Benkendorf, Charles
Beno, T. J.
Blackburn, M. D., Jr.
Boersma, J. J.
Bolles, C. S.
Brusky, A. H.
Brusky, E. S.
Burdon, T. S.
Christensen, P. D.
Clark, E. V., Jr.
Cook, F. D.
Cowles, R. L.
Crawford, C. W.
Danaher, H. H.
Denys, G. F.
Denys, K. J.
Dettmann, J. E.
Dupont, A. J.
Edelblute, L. H.
Erickson, M. R.
Forbes, K. A.
Ford, J. L.
Ford, W. W.
Freedman, A. L.
Goelz, J. R.
Grace, J. B.
Griggs, S. L.
Grossman, M. A.
Guthrie, J. M., Jr.
Hagerty, W. T.
Haines, A. W.
Halloin, J. E.
Hammes, D. A.
Hart, L. E.
Heitzman, H. H.
Hitch, O. M.
Icks, K. R.
Jansen, F. W.
Jensen, R. E.
Johnston, R. E.
Kalina, B. F.
Kaufman, J. E.
Killeen, E. R.
Killins, J. A.
Killins, W. A.
Kispert, R. W.
Koenig, Harry
Kuehl, F. O.
Kuhs, M. L.
Kulkoski, Bernard
Le Mieux, G. E.
LeTellier, M. S.
Levitas, I. E.
Lund, L. O.
Lynn, T. E.
MacMullen, Wallace, II
McCarey, Arthur J.
McCormick, R. A.
McGuire, G. E.
Mickle, K. C.
Miller, L. C.
Milson, Louis
Mokrohisky, J. F.
Myers, R. L.
Nadeau, E. G.
Nadeau, E. George, Jr.
Nellen, J. W.
Neu, V. F.
Ottum, J. A.
Oudenhoven, R. C.
Quigley, L. D.
Robb, J. J.
Rose, R. J.
Rothe, C. A., Jr.
Sandmire, H. F.
Schibly, W. J.
Schmidt, E. S.
Schmidt, R. T.
Shea, D. W.
Shinners, G. M.
Stauff, G. R.
Stiennon, O. A.
Stoll, W. M.
Sullivan, Donel
Theiler, G. J., Jr.
Theisen, J. K.
Thompson, L. L.
Troup, R. H.
Troup, R. L.
Troup, W. J.
Urban, Frank
Warpinski, M. A.
Wochos, R. G.
Wunsch, C. A.
Zucker, K. L.

Greendale:
Brown, R. J.
Ephron, E. H.
Kuglitsch, E. F.
Onderak, E. P.
Yatso, M. G.

Green Lake:
Barbour, J. H.
Leininger, A. T.

Greenwood:
Olson, W. A.

Gresham:
Litzen, F. L.

Hales Corners:
Damiano, N. F.
Joseph, W. A.
Larsen, L. L.
Pierce, D. F.
Rath, E. K.
Richter, A. M.
Sortor, R. F.
Wolf, R. C.

Hartford:
Algiers, J. L.
Hoffmann, J. G.
Hoffmann, W. C. P.
Kern, T. J.
Lehmann, F. W.
Monroe, M. E.
Quackenbush, E. C.
Quandt, V. V.
Sachse, F. W.

Hartland:
Chambers, R. K.
Ridley, J. F.
Samuelson, Clarence

Hawthorne
Shaffer, S. A.

Hayward:
Baertsch, L. M.
Callaghan, D. H.
Krueger, E. R.
Sahs, M. H.
Stang, H. M.
Wyant, M. E.

Hazel Green:
Murray, J. F.
Strauch, C. B.

Highland:
Shack, J. B.

Hillsboro:
Balder, R. E., Jr.
Boston, T. E.
Sanford, L. L.

Hollandale:
Marshall, S. B.

Horicon:
Karsten, F. A.
Karsten, J. H.
Schulz, N. H.
Schutz, W. J.

Hortonville:
Bergwall, J. G.
Towne, W. H.

Hudson:
Anderson, M. G.
Bourget, G. E.
Cornwall, M. A.
Hopkins, G. J.
Newton, J. E.

Hurley:
Martinetti, D. J.

Hustisford:
Goetsch, O. F.

Independence:
Meyer, C. F.

Iola:
Knudsen, Else
Wiley, R. H.

Jackson:
Albrecht, J. E.
Schultz, J. H.

Janesville:
Bartels, G. W.
Baumgartner, M. M.
Betlach, Dorothy W.
Betlach, Eugene H.
Boutwell, W. S.
Clark, W. T.
Dodge, R. K.
Donkle, M. J.
Farnsworth, R. W.
Fitzgerald, G. P.
Frechette, F. M.
Freitag, S. A.
Gilbertsen, C. R.
Gredler, G. P.
Gutmann, G. E.
Hartlaub, E. S.
Holland, R. A.
Johnson, W. L.
Koch, V. W.
Lardinois, C. C.
Llewellyn, M. B.
McGuire, W. H.
McNichols, E. F.
McSweeny, A. J.
Metcalf, G. S.
Nash, C. B.
Neeno, Katsumi
Nolta, R. T.
Nuzum, T. O.
Odland, P. K.
Orear, Errell T.
Otterholt, E. R.
Overton, R. S.
Pember, J. F.
Peterson, Geo. H.
Purdy, M. F.
Rau, Esther L.
Reinardy, A. L.
Reinardy, E. W.
Roesler, M. J.
Sargeant, T. S.
Schroder, John R.
Schroeder, Jack D.
Sholl, P. R.
Smith, D. A.
Snodgrass, H. M.
Tarrasch, Hertha
Thomas, G. L.
Tomlinson, Carol
Tordoff, J. J.
Welch, F. B.

Jefferson:
Brewer, J. C.
Busse, A. A.
Quandt, C. E.
Quandt, R. W.
Robinson, A. H.

Johnson Creek:
Wendt, F. A.

Juneau:
Ferguson, E. C.
Heath, H. J.

Kaukauna:
Bachhuber, A. E., Jr.
Bachhuber, A. M.
Behnke, G. A.
Boyd, G. L.
Cherkasky, Simon
Jeffrey, J. S.
Russo, J. G.
Skibba, J. P.

Kenosha:
Altman, J. S.
Ambro, P. J.
Andre, E. F.
Armstrong, G. F.
Ashley, R. W.
Barnes, E. H., III
Bilak, R.
Binnie, Helen A.
Bjork, H. A.
Block, R. M.
Bode, M. J.
Bonell, B. T.
Creighton, L. H.
Creswell, C. M.
Currie, R. E.
Davin, C. C.
Davis, D. W.
Davison, T. H.
DeFazio, S. F.
Duncan, J. T., Jr.
Garren, J. T.
Goldstein, D. N.
Graves, J. P.
Hatfield, M. E.
Hill, B. Spalding
Holt, S. H.
Horsley, D. B.
Kappus, H. C.
Kent, L. T.
Kleinpell, W. C.
Lawrence, P. J.
Lipman, W. H.
Lokvam, L. H.
Lutz, J. J.
Mayfield, A. L.
Meeter, U. L.
Milliken, L. D., Jr.
Morrow, C. A.
Mudge, W. A., Jr.
Olsman, Louis
Pearson, J. B.
Pechous, C. E.
Pechous, Lillian
Powell, R. A.
Randall, A. J.
Rattan, W. C.
Rauen, L. M.
Richards, J. N.
Ruehlman, D. D.
Rufflo, A. F.
Sattler, C. A.
Schlenker, L. T.
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.

Siegel, Morris
Swift, W. J., Jr.
Turner, Lewis, III
Ulrich, C. F.
Weber, G. R.
Welsch, R. G.
Whetstone, O. H.
Williams, F. C., Jr.
Wood, Fredrick, Jr.

Keshena:

Rivard, R. R.

Kewaskum:

Edwards, R. G.

Kewaunee:

Lanier, A. S.
Lanier, Patricia F.
Nesemann, R. M.
Wits, E. W.

Kiel:

Nauth, D. F.
Theiler, A. C.
Twohig, G. J.

Kimberly:

Curtin, D. W.
Gage, Ralph S.

Kohler:

Gascoigne, C. C.
Rowe, D. M.

La Crosse:

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Anderson, E. M.
Anderson, N. P.
Anderson, P. D.
Bach, A. C.
Britt, A. G.
Buchman, D. M.
Carlsson, E. S.
Cejpek, K. O.
Cook, A. A.
Corser, D. H.
Daley, D. M.
Dalton, R. M.
Dietz, P. C.
Doyle, D. F.
Durst, J. B.
Egan, G. J., Jr.
Egan, J. F.
Ellenz, G. B.
Ernst, F. W.
Fisher, A. L.
Flynn, R. E.
Fox, J. C.
Gallagher, E. E.
Gallagher, F. J.
Gallagher, W. B.
Gatterdam, P. C.
Getz, Kaare
Gilbert, R. L.
Gilles, Paul L.
Gorenstein, L. M.
Gundersen, A. H.
Gundersen, A. L.
Gundersen, G. A.
Gundersen, Gunnar
Gundersen, S. B.
Gundersen, S. B., Jr.
Gundersen, T. E.
Harman, J. C.
Hayden, J. W.
Helliesen, P. J.
Hickey, A. W.
Himmelsbach, W. A.
Hulick, P. V.
Jaeck, James L.
Jensen, Alfhild
Jones, W. J.
Joseph, L. G.
Leiby, R. W., Jr.
MacEwen, A. R.
Mansheim, B. J.
McCann, John P.
McGarty, M. A.
McMahon, R. E.
McNamara, T. B.
Midelfort, C. F.
Murphy, G. B., Jr.
O'Meara, M. T.
Pauly, James P.
Perry, E. L.
Phillips, P. W.
Pribek, R. A.
Ramlow, R. W.
Rasmus, R. B.
Richter, J. R.
Satory, J. J.
Scheurich, Mary B.
Schmidt, L. R.
Schneeberger, E. J.
Schuldes, R. E.
Sevenants, J. J.
Simones, J. J.
Simonson, S. W.
Sivertson, Martin
Sivertson, S. E.
Skemp, F. C.
Skemp, G. E.
Skemp, J. T.
Slungaard, Rolv
Thompkins, D. G.
Uhrich, G. I.
Voss, E. C., Jr.
Watunya, M. J.
Wolf, F. H.

Ladysmith:

Bauer, W. B. A. J.
Bennett, R. P.
Murphy, J. E.
Pagel, H. F.

La Farge:

Gollin, F. F.

Lake Geneva:

Beattie, J. W.
Bischof, H. F.
Hindall, B. C.
Hudson, E. D.
Jeffers, D. H., Jr.
Rauch, A. M.

Lake Mills:

Eck, G. E.
Liebenow, R. R.
Netzow, E. J.
Peterson, M. G.
Turcott, R. A

Lancaster:

Bauman, K. L.
Becher, L. E.
Carey, H. W.
Houghton, E. M.

Land O'Lakes:

Eickhoff, E. C.

Laona:

Castaldo, E. F.
Ovitz, E. G.

Lena:

Rose, J. F.

Little Chute:

Van Lieshout, F. X.

Lodi:

Groves, R. J.
Irwin, W. G.

Loyal:

Hable, A. P.

Luxemburg:

Majeski, H. E.
Rahr, H. C.

Madison:

Aageson, C. W.
Ainslie, R. B.
Albright, E. C.
Allen, J. C.
Allen, J. R.
Allin, R. N.
Anderson, A. D.
Anderson, Jeanne
Anderson, R. B.
Angevine, D. M.
Ansfield, F. J.
Aronson, Abraham
Ashman, H. C.
Bachhuber, T. E.
Bamforth, Betty J.
Barreto, R. S. O.
Bartlett, W. H.
Becker, R. M.
Beilman, R. L.
Belknap, E. L., Jr.
Bell, P. P.
Benish, G. A.
Bennett, Maxine
Bentley, J. E.
Berg, Mary C.
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Berglund, George A. J.
Bernard, F. D.
Blum, F. G., Jr.
Bogle, W. C.
Bohlman, D. C.
Boldon, E. L., Jr.
Borenz, H. F.
Botham, R. J.
Bowers, J. Z.
Brindley, B. I.
Britton, D. M.
Brown, Henry
Brucker, E. A.
Bryan, A. W.
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Burke, Myra E.
Burnett, G. H.
Burns, E. M.
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Campbell, R. E.
Carr, R. D.
Carter, H. M.
Chase, S. L.
Clatanoff, D. V.
Clausen, N. M.
Collins, R. F.
Connors, D. M.
Cooksey, R. T.
Cooper, G. A.
Coryell, J. L.
Cowle, A. E.
Crepea, Seymour B.
Crocker, L. G.
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Crummy, A. B., Jr.
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Dimond, W. B.
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Domine, A. Z.
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Ehrlich, F. E.
Eichman, P. L.
Ellis, J. C., Jr.
Erickson, M. T.
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Evans, A. S.
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Flinn, John H.
Forster, F. M.
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Geppert, T. V.
Giles, L. T.
Glover, B. H.
Goldbeck, L. O.
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Gordon, E. S.
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Halleck, S. L.
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Hank, G. C.
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Hartridge, T. L.
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Hogan, L. H.
Holmgren, L. E.
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Hummer, F. L.
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Jackson, C. R.
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Jaeschke, W. H.
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Javid, Manucher
Joachim, F. G.
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Juster, E. M.
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Keepman, Jay P.
Kemp, T. S.
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Kundert, P. R.
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Land, J. F.
Lange, R. D.
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Lemmer, K. E.
Leonard, T. A., Jr.
Lewis, W. C.
Liebl, E. R.
Lindsay, W. T.
Lipp, Evelyn D.
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Longley, B. J.
Loveland, Pearl M.
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Lyons, W. H.
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Marlow, Gordon V.
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McGrath, D. J.
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McIntosh, J. F.
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Miller, M. H.
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Mohs, F. E.
Moore, J. N.
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Mussey, W. C.
Neal, M. P., Jr.
Nereim, T. J.
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Neupert, C. N.
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Oakley, Dorothy W.
O'Connor, Robert E.
Okagaki, H. I.
Olson, R. W.
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Orth, O. S.
Osborn, L. A.
Owen, R. H.
Parks, H. K.
Parsons, W. B., Jr.
Paul, L. W.
Peckham, B. M.
Pellett, J. R.
Peters, H. A.
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Piper, P. G.
Pitts, F. R., Jr.
Pohle, E. A.
Preizler, Josef
Price, D. O.
Prouty, L. R.
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Ptacek, L. J.
Puestow, K. L.
Puletti, F.
Purcell, E. F.
Quisling, A. A.
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Rahm, J. P., Jr.
Reeck, L. K.
Reese, H. H.
Reznichek, C. G.
Richtsmeier, A. J.
Ris, Hania W.
Roberts, L. M.
Roberts, T. S.
Rock, William
Roemer, E. P.
Rogers, S. C.
Roisum, B. H.
Rotter, Royal
Rounds, W. M.
Rowe, G. G.
Ryder, E. K., Jr.
Sabin, Richard P.
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Samp, R. J.
Schafer, Etheldred L.
Schilling, R. F.
Schmidt, C. S.
Schmidt, E. R.
Schmitz, R. C.
Schneiders, E. F.
Schoenenberger, A. P.
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Schroeder, J. M.
Schubert, C. K.
Schultz, A. E.
Scott, J. K.
Shapiro, H. H.
Sheldon, E. O., Jr.
Shropshire, R. W.
Shumate, J. K.
Siebecker, K. L., Jr.
Sims, J. L.
Slnaiko, R. P.
Sisk, I. R.
Skroch, E. E.
Smith, D. B.
Smith, Max M.
Smyth, I. P.
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Sprague, J. T.
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Stehr, A. C.
Stiennon, GG. A., Jr.
Stoerker, Ruth A.
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Stoops, C. W.
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Straughn, R. A.
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Suckle, H. M.
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Tenney, Horace K., III
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Thornton, Madeline J.
Tormey, A. R.
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Toussaint, J. B.
Turgeson, J. H.
Tweeten, J. K.
Tybrlng, G. B.
Urben, W. J.
Van Duser, A. L.
Van Gemert, J. G.
Vanstane, V R.
Vastola, A. P., Jr.
Vermund, Halvor
Vingom, C. O.
Vinograd, S. P.
Vogt, G. H.
Waddell, J. G.
Walsh, E. G.
Walsh, L. G.
Walter, W. H.
Washburn, W. L.
Washburne, Annette C.
Waskow, W. L.
Wasserburger, R. H.
Waters, D. D.
Wear, J. B.
Weatherhogg, C. R.
Weinstein, A. B.
Welke, E. G.
Werrell, W. A.
Weston, F. L.
Wheeler, B. C., Jr.
Wheeler, R. M.
Whitsltt, R. E.
Wilkie, J. M.
Williams, D. L.
Winston, Margaret C.
Wirig, M. H.
Wirka, H. W.
Wixson, R. C.
Wolberg, W. H.
Wong, H. C.
Woods, S. M.
Worley, Gordon, Jr.
Wylde, R. M.
Ylitalo, W. H.
Young, W. P.
Zabors, T. E.
Zimmer, R. W., Jr.

Manawa:

Irvine, R. K.

Manitowoc:

Arnold, T. S.
Banker, R. J.
Belson, H. J.
Bonner, N. A.
Davis, N. S., Jr.
Erdmann, N. C.
Evensen, N. A.
Hammond, F. W.
Hammond, R. W.
Hoffman, G. M.
Lynch, J. D.
MacLean, C. R.
Perry, T. K.
Pick, D. M.
Puestow, R. C.
Radl, C. J.
Randolph, R. C.
Randolph, W. C.
Rauch, W. A.
Rees, T. H.
Schaefer, H. E.
Scherping, W. H.
Schochet, S. S.
Shaw, Jesse W., Jr.
Simon, G. M.
Smejkal, W. F.
Sobush, L. D.
Stannard, G. H., Jr.
Steckbauer, J. W.
Strong, R. G.
Teitgen, T. A.
Thorpe, R. F.
Wall, C. E.
Webster, J. G.
Yost, R. G.

Marathon:

Kampine, C. E.

Maribel:

May, J. H.

Marinette:

Bell, J. M.
Boren, C. H.
Boren, Clark H.
Boren, J. A.
Boren, J. W., Jr.
Koepp, C. E.
Moss, K. J.
Pinegar, K. G.
Zeratsky, J. D.

Marion:

McInnis, W. R.

Markesan:

Cupery, D. P.

Marshall:

Schmidt, C. W.

Marshfield:

Baldwin, Elizabeth
Baldwin, R. S.
Bodmer, R. E.
Bowerman, C. I.
Burns, J. L., Jr.
Custer, G. S.
Doege, K. H.
Doege, P. F.
Emanuel, D. A.
Epstein, Stephan
Glassy, F. J.
Gouze, F. J.
Grlese, G. G.
Heersma, J. R.
Helland, N. J.
Heywood, W. H.
Larkin, W. B.
Lawton, B. R.
Lewis, R. F., Jr.
Lohrenz, F. N.
Macht, A. J.
Magnin, George E.
Manier, J. W.
Mason, R. W.
McCormick, G. L.
McKenty, J. D.
Osborne, J. V.
Ousley, J. L.
Pederson, D. P.
Potter, R. P.
Rice, T. J.
Rowe, R. J.
Rupel, J. W.
Salibi, B. S.
Schloesser, L. L.
Schmidt, C. W.
Suits, J. J.
Taylor, R. D.
Vedder, C. A.
Vedder, J. S.
Waters, H. S.
Wlckham, J. M.
Wlliams, G. H.
Wink, R. H.

Mauston:

Griffin, V. M.
Hess, J. S., Jr.
Strong, Jack
Tverberg, M. S.
Vedner, J. H.

Mayville:

Bachhuber, F. G.
Parish, G. A.
Royce, M. E.

Mazomanie:

Schultz, Isadore

Medford:

Meyer, W. W.
Nystrum, L. E.
Nystrum, R. C.

Mellen:

Lockhart, C. W.

Menasha:

Buran, D. J.
Conway, J. E.
De Morest, H. F., Jr.
Forkin, G. E.
Hildebrand, G. B.
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Jensen, F. G.
Jensen, R. A.
Nebel, J. R.
Pratt, G. N., Jr.
Schwei, G. P.
Wainscott, P. E.

Menomonee Falls:

Burnett, R. G.
Domann, W. A.
Domann, W. G.
Harrington, K. J.
Heyrman, D. J.
Nickels, R. J.
Schloemer, H. F.
Schmidt, J. R.

Menomonie:

Belza, Janusz
Buckley, C. H.
Crippen, D. A.
Drescher, A. A.
Halgren, J. A.
Lee, S. R.
Lumsden, William
McMahon, A. E.
Nolan, J. L., Jr.
Quilling, P. A.
Tweeten, J. B.

Mequon:

Kim, K. S.
Schulz, H. F. W.

Mercer:

Hogan, John
Kleinboehl, J. W.

Merrill:

Bayer, L. J.
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Bigalow, J. F.
Braun, W. E.
Kelley, F. H.
Lane, F. C.
Lewinnek, Walter
Millenbah, J. D.
Morris, K. A.
Ravn, E. O.
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Middleton:

Heighway, T. F.
Stricker, M. F.

Milltown:

Ericksen, D. M.

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Burdick, H. L.
Davis, M. D.
Lyons, R. P.

Milton Junction:

Holmes, J. F.
Klein, T. W.
Vogel, T. L.

Milwaukee:

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Ackerman, J. S.
Adamkiewicz, J. J.
Adlam, R. T.
Aguirre, M. R.
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Albrecht, D. J.
Altshuler, C. H.
Amberg, John
Ansfield, D. J.
Antonmattel, Jean C.
Apfelberg, H. J.
Aquino, Manuel
Arkins, J. A.
Armbruster, J. L.
Askot, M. M.
Atkinson, C. T.
Ausman, D. C.
Ausman, H. R.
Avellone, B. M.
Aylward, T. J.
Babbitt, D. P.
Babbitz, A. L.
Babbitz, S. G.
Babby, Louis
Bach, M. J.
Bachhuber, E. A.
Bachman, C. H.
Backus, E. A.
Baier, A. R.
Baird, W. W.
Baker, V. L.

Balistreri, Frank
Ballard, M. D.
Balzer, R. R.
Bardenweiper, H. E.
Bares, G. C.
Bareta, John
Barnes, R. O.
Barnett, S. M.
Baron, J. J.
Barrock, J. J.
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Bartos, R. E.
Bauch, N. G.
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Bauman, R. O.
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Bender, B. I.
Benjamin, H. B.
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Berlow, Stanley
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Berridge, F. E., Jr.
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Bremer, E. M.
Brennan, J. J.
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Busby, W. W.
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Bussey, A. D.
Buszkiewicz, T. S.
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Waxman, S. I.
Webb, W. C.
Weber, A. J.
Weber, J. E.
Weber, M. L.
Wegmann, G. H.
Weil, H. R.
Weln, Benjamin
Weingarten, Maxwell
Weinshel, L. R.
Weinstein, J. D.
Weis, T. W.
Weisel, Wilson
Weisenthal, C. L.
Welsfeld, S. G.
Weisfeldt, S. C.
Weller, R. R.
Wells, Marvin
Welsh, E. C.
Wendt, W. P.
Wepfer, J. F.
Werba, D. R.
Werner, D. J.
Wetzler, S. H.
Whalen, G. E.
Whitaker, P. J.
Wiese, M. E. J.
Wild, J. P.
Wllets, J. B.
Wilets, J. C.
Williams, Claiborne
Williams, DeLore
Willson, D. M.
Winnik, D. E.
Wirthwein, C. L.
Wisniewski, P. P.
Witte, D. H.
Wolf, L. P.
Wolfe, C. W.
Wolfgram, R. C.
Woloschek, W. J.
Wolski, L. R.
Wolter, S. H.
Wolters, H. F.
Wong, V. J.
Worm, G. J.
Worman, L. W.
Wright, H. H.
Wyland, J. S.
Wyman, J. F.
Wynn, S. K.
Yellick, C. W.
Young, H. C.
Young, W. N.
Yunck, R. E.
Zastrow, R. C.
Zaun, J. J., Jr.
Zautcke, A. B., Jr.
Zawodny, S. E.
Zellmer, R. E.
Zeps, A. A.
Ziegler, C. T.
Ziehl, F. L.
Zillmer, Helen J.
Zimmermann, B. M.
Zmyslony, W. P.
Zubatsky, D. J.
Zupnik, G. R.

Mineral Point:
Hamlin, W. D.
Hohler, E. J.
Ludden, H. D.
White, C. L.

Minocqua:
Ashe, H. S.
Huber, G. W.

Mishicot:
Nilles, J. E.

Mondovi:
Sharp, D. S.
Walker, J. P.
Wright, W. E.

Monroe:
Barry, G. R.
Baumle, C. E.
Bear, N. E.
Brunkow, B. H.
Cales, J. O.
Chandler, Arthur, Jr.
Eckstam, E. E.
Fencil, W. J.
Frantz, J. A.
Irvin, J. M.
Kindschi, L. G.
Kundert, F. W.
Miller, C. O.
Miller, D. D.
Mings, D. E.
Moore, L. A.
Olson, M. J.
Springer, D. W.
Staab, W. J., Jr.
Stiles, F. C.
Stormont, J. R.
Weir, J. R.
Wichser, R. F.
Witte, K. B.
Zach, R. G.
Zupanc, E. A.

Montello:
Federman, E. H.
Inman, R. F.

Montfort:
Breier, H. P.

Monticello:
Stovall, W. D., Jr.

Montreal:
Pierpont, J. M.

Mosinee:
Knoedler, W. H., Jr.

Mount Calvary:
Miller, J. F.

Mount Horeb:
Morrison, M. T.

Mukwonago:
Kern, E. E.
Rosenkranz, W. E.
Zwisler, E. E.

Muscoda:
Ackerman, E. T.
Klockow, W. E.

Muskego:
Buhl, J. L.
Kelm, G. J.

Neenah:
Anderson, G. R.
Arndt, G. W., Sr.
Beatty, S. R.
Beglinger, H. F.
Bonfiglio, R. G.
Brown, R. C.
Brunckhorst, F. O.
Canavan, J. P.
Colgan, H. J.
Graham, A. P.
Hardie, G. H.
Henning, R. E.
Kirchgeorg, Clemens
Pansch, F. N.
Petersen, G. W.
Quade, R. H.
Regan, D. M.
Ryan, D. J.
Schwab, R. L.
Smith, F. H.
Springer, V. G.
Suechting, R. L.
Talbot, A. E.

Neillsville:
Manz, K. F.
Overman, M. V.
Rosekrans, M. C.
Rosekrans, Sarah D.
Thompson, T. N., Jr.

Nekoosa:
Jerofke, Alfred
Pfeiffer, L. R.
Thompson, J. E.

New Berlin:
Komar, R. R.
Schofield, Raymond
Selle, F. S.

New Franken:
Looze, J. A.

New Glarus:
Hicks, E. V.
Marty, P. H.

New Holstein:
Engel, A. C.
Larme, F. P.

New Lisbon:
Koch, C. B.
Weston, C. L.

New London:
Dernbach, G. P.
Monsted, J. W.
Pfeifer, F. J.
Schmallenberg, H. C.
Weber, J. W.

New Richmond:
Armstrong, J. H.
Craig, J. L.

Davis, R. R.
Drury, E. M.
Epley, O. H.
Healy, J. P.
Weisbrod, L. W.

Niagara:
Maginn, Richard J.
McCormack, E. A.

Norwalk:
Allen, J. S.

Oconomowoc:
Burch, R. N.
Claude, J. L.
Driscoll, L. J.
Frank, E. B.
Gallo, G. L.
Goral, T. J.
James, W. D.
Janssen, W. C.
Loughnan, A. J.
Matt, J. R.
Miller, G. D.
Nammacher, T. H.
Rheineck, A. F.
Rogers, A. F.
Schuele, D. T.
Schumacher, B. J.
Schumacher, J. P.
Stemper, Irene T.
Theobald, P. B.
Weir, E. F.
Wilkinson, D. C.
Wilkinson, J. D.
Wilkinson, J. F.
Wilkinson, P. M.

Oconto:
Aageson, H. A.
Mohler, G. T.
Zantow, F. E.

Oconto Falls:
Culver, J. R.
Siefert, C. E

Omro:
Peck, D. D.
Schoenbechler, L. J.

Onalaska:
Gray, R. H.
Reay, G. R.

Oregon:
Dukerschein, F. N.
Johnson, E. S.
Kellogg, L. S.

Orfordville:
McNair, E. R.

Osceola:
Simenstad, L. O.
Weller, L. J.

Oshkosh:
Apell, M. G.
Becker, D. B., Jr.
Behnke, C. H.
Bitter, R. H.
Clark, W. E.
Connell, F. G.
Cummings, E F.
Danforth, H. J.
Danforth, Q. H.
Enrich, P. S.
Gerth, R. E.
Graber, L. D.
Graiewski, S. J.
Greenwood, Ben. S.
Guenther, O. F.
Guenther, V. G.
Hahn, W. V.
Haines, M. C.
Haubrick, H. J.
Hillenbrand, H. M.
Koehler, A. G.
Kronzer, J. J.
Kuhn, R. V.
Leibenson, S. J.
Leschke, John A.
Meilicke, C. A.
Meli, J. V.
Monday, Harvey
Payne, J. C.
Petersik, J. T.
Pfefferkorn, E. B.
Romberg, H. A.
Scheuermann, N. M.
Steele, G. A.
Steen, M. H.
Stone, L. H.
Strakosch, E. A.
Wagner, R. F.
Wagner, W. A.
Wheeler, W. P.
Williams, E. B.
Winter, E. F.
Wright, E. N.
Zmolek, E. J.

Osseo:
Knutson, Oscar

Owen:
Braswell, H. M., Jr.

Palmyra:
Handeyside, R. G.

Pardeeville:
Westcott, T. S.
Winkler, H. A.

Park Falls:
Leahy, J. D.
Murphy, J. L.

Pell Lake:
Roenau, Elly A.

Peshtigo:
Barrette, Antoine
Blahnik, C. L.

Pewaukee:
Egloff, L. W.
Kelly, J. P.

Phillips:
Niebauer, W. E.
Rens, J. L.
Van Hecke, D. S.

Plain:
Fowler, Paul H.
Galarnyk, I. A.

Platteville:
Andrew, C. H.
Cunningham, Wilson
Doeringsfeld, H. L.
McCumber, M. L.
Moffett, J. L.
Steidinger, C. L.

Plum City:
Erickson, B. R.

Plymouth:
Brickbauer, A. J.
Dietsch, L. C.
Evers, R. H.
Mueller, J. F.
Radloff, A. C.
Steffan, L. J.
Weisse, H. A.

Portage:
Cooney, R. T.
Henney, C. W.
Henney, T. E.
Jones, W. W.
MacGregor, J. W.
Pavelsek, J. W.
Rueckert, R. R.
Saxe, J. J.
Taylor, S. F.
Taylor, W. A.
Tierney, E. F.

Port Edwards:
Backus, O. A.

Port Washington:
Barr, A. H.
Biever, P. H.
Henkle, R. F.
Kauth, C. P.
Muehlhaus, F. R.
Savage, G. F.
Walsh, John F.

Pound:
Pelkey, R. B.

Poynette:
Dryer, R. B.
Focke, W. J.
Stevenson, D. J.

Prairie du Chien:
Dessloch, E. M.
Epley, V. C.
Farrell, T. F.
Satter, O. E.
Shapiro, H. L.
Wong, J. R.

Prairie du Sac:
Bishop, P. R.
Trautmann, Milton
Zauft, G. W.

Prairie Farm:
Roemhild, F. N.

Prescott:
Laney, H. J.

Princeton:
Mueller, G. G.

Pulaski:
Brusky, S. F.
Shippy, V. J.

Racine:
Ageloff, Harry
Albino, J. M.
Bacon, G. A.
Baernstein, H. D.
Barina, H. J.
Bennett, W. H.
Bliwas, Arnold
Brehm, H. G.
Brehm, H. J.
Brewer, G. W.
Bruton, J. T.
Buckley, W. E.
Burch, V. J.
Christensen, F. C.
Christenson, C. W.
Constantine, C. E.
Cook, J. C.
Covell, K. W.
DeGroot, H. E.
Dockery, J. N.
Docter, J. C.
Dorman, T. W.
Edwards, A. C.
Faber, S. J.
Fazen, L. E.
Fazen, L. E., Jr.
Fogle, R. J.
Fralich, J. C.
Gradetto, P. A.
Gehring, C. A.
Gerol, A. Y.
Gillett, G. N.
Graf, A. E.
Grant, A. B.
Grinney, June L.
Grinney, L. R.
Harris, W. C.
Hemmingsen, T. C.
Henken, J. F.
Henken, W. F.
Hilker, H. C.
Hilpert, F. M.
Hogan, J. H.
Holman, J. H.
Jacobsen, A. J.
Jamieson, J. G.
Johnson, P. S.
Jones, Beatrice O.
Jones, L. E.
Kaarakka, O. F.
Kadin, Maurice
Kehl, K. C.
Keland, H. B.
Konnak, Wm. F.
Kreul, R. W.
Kreul, W. R.
Kurten, L. J.
Kurten, R. M.
Lauerman, E. P.
Lehner, R. H.
Leitschuh, R. B.
Lifschutz, L. M.
Lindner, A. M.
Little, W. J., Jr.
MacVicar, E. L., Jr.
Madden, W. J.
Marek, F. B.
Mayer, R. J.
McHale, J. A.
Miller, H. C.
Miller, P. L.
Miller, W. C.
Minton, Richard
Nelson, M. W.
Newman, C. R.
Nickelsen, J. R.
Oberdorfer, C. E.
Olson, E. S.
Petersen, J. J. G.
Pfeifer, E. C.
Pinkus, W. H.
Pope, F. W.
Postorino, J. D.
Roth, W. C.
Rothenmaier, G. L.
Schacht, E. W.
Schacht, R. J.
Scheible, F. J.
Scheller, R. F.
Schenkenberg, Grace E.
Schleper, A. J.
Schroeder, H. T.
Schuster, Myron
Skow, G. D.
Skupniewicz, R. E.
Smith, L. W.
Smollen, W. J.
Smullen, G. H.
Steffen, Elizabeth A.
Stika, E. A.
von Jarchow, B. L.
Walters, H. G.
Williamson, W. H.
Wright, R. S.

Randolph:
Horvath, D. C.

Random Lake:
Russell, J. A.

Reedsburg:
Booher, J. A.
Hanko, J. E.
Knight, Robert G.
Pawlisch, O. V.
Rouse, J. J.
Stadel, E. V.
Tibbitts, J. A.

Rhinelander:
Brown, J. F.
Bump, W. S.
Cline, Frances A.
Haug, Thomas M.
Johnson, A. G.
Mescher, T. J.
Nik Nevin, Ismail
Osborne, R. R.
Pratt, G. F.
Rosemeyer, O. G.
Schiek, I. E.
Schiek, I. E., Jr.
Simmons, W. K.
Thuerer, G. R.

Rib Lake:
Pettera, R. L.

Rice Lake:
Cotts, L. R.
Eidsmoe, N. A.
Engels, E. P.
Kristensen, L. A.
Maser, J. F.
McKenzie, J. R., Jr.
Rydell, O. E.
Rydell, W. B.

Richland Center:
Crandall, G. H.
Edwards, W. C.
Glise, Roy C.
Hinke, D. H.

Housner, R. E.
Meyer, K. H.
Parke, George, Jr.
Pippin, L. M.
Sholtes, C. A.
Spear, Jack
Taft, D. J.

Rio:
Langmack, W. A.
Maas, W. C.

Ripon:
Bachus, A. C.
Cole, D. F.
Dittmer, O. A.
Johnson, J. M.
La Ham, J. T.
Pelton, R. S.
Schuler, W. H.
Sundeen, R. A.
Watson, E. L.

River Falls:
Cairns, R. U.
Grassl, F. O.
Gutzler, P. H.
Hammer, R. M.
Haskins, P. S.

Rosholt:
Benn, V. A.

St. Croix Falls:
Belshe, J. C.
Ericksen, D. M.
Fink, D. W.
Olson, L. L.
Riegel, F. B.
Riegel, J. A.
Wegner, M. E.

St. Nazianz:
Foley, M. E.

Sauk City:
Bachhuber, H. A.
Kraus, B. F.
Walsh, T. W.

Seymour:
Groendahl, R. C.
Hittner, V. J.
Sieb, L. H.

Sharon:
Schrock, J. B.

Shawano:
Arvold, D. S.
Cantwell, A. A.
Cantwell, R. C.
Jeffries, Donald A.
Laufenburg, H. F.
Marsh, H. C.
Peterson, L. W.
Sebesta, A. J.
Toll, R. J.
Von Ruden, W. J.

Sheboygan:
Ashby, A. O.
Bassewitz, P. P.
Bock, A. B. C.
Bringe, J. W.
Clnelis, Ann A.
Differt, C. C.
Duckering, Florence A.
Eckardt, B. F.
Eigenberger, Friedrich
Gruenewald, Ludwig
Heinz, H. N.
Hidde, F. G.
Hildebrand, G. J.
Hildebrand, J. F.
Hoon, J. R.
Houfek, E. E.
Hougen, E. T.
Huibregtse, W. G.
Knauf, A. J.
Kolb, F. K.
Kovacic, J. F.
Marsho, B. S.
Mason, P. B.
McRoberts, J. W.
Meier, Wm. G.
Moir, Jane M.
Moir, W. W.
Mooney, F. L.
Nause, F. A.
Nause, F. P.
O'Donnell, S. P.
Pauly, L. F.
Pauly, R. C.
Schlichting, J. E.
Schott, E. G.
Schroeder, I. L.
Sciarra, P. A.
Senty, R. M.
Simonson, L. M.
Simpson, R. M.
Tasche, C. T.
Tasche, J. A.
Tasche, L. W.
Tompsett, A. C.
Van Driest, J. J.
Weber, C. J.
Werner, D. A.
Windsor, R. B.
Winsauer, H. J.
Wood, R. A.

Sheboygan Falls:
Hansen, H. J.
Leighton, F. A.
Weygandt, J. L.

Shell Lake:
Moen, D. V.
Welter, D. J.

Shiocton:
La Croix, G. M.

Shullsburg:
Garland, D. J.
Gratiot, Mary P.
Hoesley, H. F.

Silver Lake:
De Witt, C. A.

Slinger:
Prefontaine, K. F.

Soldiers Grove:
Sannes, W. A.

South Milwaukee:
Crigler, R. R.
Dempsey, G. P.
Flaherty, G. S.
Grimm, J. J.
Murphy, G. V.
Oberfeld, H. H.
O'Leary, W. J.
Theisen, C. E.
Turgai, Valerio
Zahl, W. H.

South Wayne:
Creasy, L. E.

Sparta:
Beebe, D. C.
Beebe, S. D.
Brown, J. D.
Harris, A. J.
Lukasek, E. O.
Mannis, Harry
Van Susteren, J. A.
Williams, H. H., Jr.

Spencer:
Callahan, H. T.

Spooner:
Goetsch, F. H.
Matzke, R. W.
Olson, L. J.

Spring Valley:
Docter, C. W.

Stanley:
La Breche, J. J.
Mathwig, R. J.
Overgard, A. W.

Stevens Point:
Anderson, G. H.
Anderson, H. A.
Benn, H. P.
Bickford, R. H.
Crosby, E. P.
Dunn, A. G.
Erickson, J. R.
Gehin, F. E.
Gramowski, W. A.
Grinvalsky, H. T.
Iber, F. C.
Kohn, A. M.
Litzow, J. A.
Miller, S. R.
Reichardt, F. W.
Rice, M. G.
Rifleman, R. H.
Riordan, J. F.
Sanders, R. H.
Sevenich, J. R.
Sheehan, W. C.
Slater, R. H.
Sowka, A. J.
Sowka, P. N.
Wisiol, Erich

Stockbridge:
Knauf, J. A.

Stoughton:
Hermundstad, O. A.
Nordholm, V. W.
Peterson, R. K.
Schammel, F. M.
Schoenbeck, R. F.
Smedal, A. T.

Stratford:
Kroeplin, F. C.

Sturgeon Bay:
Beck, J. G.
Brook, J. J., Jr.
Dorchester, D. E.
Grota, H. D.
Hobson, W. S.
Muehlhauser, J. O.
Murphy, J. T.
Sheets, W. G.

Sun Prairie:
Behrend, J. F.
Grab, J. A.
Nelson, E. J.
Peterson, Leo W.
Roley, E. L.
Russell, W. T.

Superior:
Aktekin, Hikmet
Anderson, R. T.
Carpenter, E. E.
Doyle, T. J.
Droege, C. T.
Ekblad, V. E.
Finn, Milton
Foderick, J. W.
Fruehauf, R. P.
Giesen, Charles W.
Giesen, Conrad W.
Heisel, J. G.
Johnson, F. G., Jr.
Lavine, I. H.
Lavine, M. M.
Mataczynski, R. R.
McGill, J. W.
McGinnis, J. P.
Picard, C. J.
Rosin, L. R.
Sincock, H. A.
Stack, E. G., Jr.
Thompson, R. T.
Weisberg, J. H.

Suring:
Sandgren, G. R.

Sussex:
Mateicka, W. E.
Van Valin, E. C.

Theresa:
Langenfeld, G. P.

Thiensville:
Elbe, T. D.
Herman, Murray
Levy, E. S.
McCabe, R. W.
Scholz, H. F.

Thorp:
Jorgensen, Eleanora F.
Jorgensen, P. B.
Neis, F. P.

Tigerton:
Heise, L. F.

Tomah:
Bittle, K. A.
Konicek, R. G.
Kozarek, C. E.
Landmann, G. A.
Mubarak, J. S.
Seno, E. C.

Tomahawk:
Adams, H. G.
Baker, G. R.
Baker, R. G.
Henderson, R. J.
Jarvis, D. F.
Jarvis, E. C.
McCormick, W. C.
Rouman, W. C.

Turtle Lake:
Halberg, A. C.

Two Rivers:
Kaner, S. L.
Kozelka, A. W.
Kuljis, D. A.
Martin, R. E.
Weld, S. L.
Zlatnik, A. P.

Union Grove:
Haedike, W. D.
McCracken, R. W.
McGinnis, H. J.
Schulz, G. J.
Winter, R. V.

Valders:
Acheson, W. E.

Verona:
Noll, D. J.
Smith, V. W.

Viroqua:
Ender, C. A.
Gulbrandsen, L. F.
Kuehn, A. E.
Oppert, H. E.
Skinsnes, C. C.
Starr, R. A.
Vig, D. E.
Vig, De Verne W.
Vig, E. N.

Wabeno:
Tenley, O S.

Walworth:
Bruhn, I. J.
Coon, W. W.
Kroyer, T. J.

Washburn:
Guzzo, Harold

Waterford:
Bardenwerper, H. W.
Dietz, R. J.

Waterloo:
Fowler, J. R.
Garman, J. S.
Kennedy, F. H.

Watertown:
Baldwin, R. C.
Becker, J. H.
Burzynski, E. E.

Doyle, R. F.
Epperson, D. P.
Hahn, A. C.
Marshall, W. S.
Miller, E. A.
Schuh, E. P.
Welbourne, R. P.
Zimmermann, F. H.

Waukesha:
Alston, J. A.
Bartos, J. A.
Bischel, J. R.
Bolger, James V.
Brown, W. E.
Campbell, P. E.
Campbell, W. B
Carroll, P. E.
Clothier, W. J. K.
Davies, E. B.
Davies, Gwilym
Dugan, T. E.
Edmondson, C. C.
Elson, C. E.
Feulner, R. C.
Frantz, R G.
Gantz, H. A.
Guy, J. R.
Kaschl, R. L.
Kritter, A. E.
McDonell, T. H.
Merkow, William
Monk, R. S.
Motzel, A. J., Jr.
Promer, J. E.
Schmidt, C. W.
Schulz, E. G.
Selle, F. S.
Settlage, H. A.
Smirl, W. G.
Sweed, Aaron
Sydow, H. F.
Thompson, F. A.
Werra, B. J.
Werra, M. J.
Wood, C. A.
Zietlow, F. G.

Waunakee:
Hopkins, C. E.
Marquis, W. R.

Waupaca:
Boudry, M. O.
Haman, K. L.
Salan, Sam
Steiner, J. H.

Waupun:
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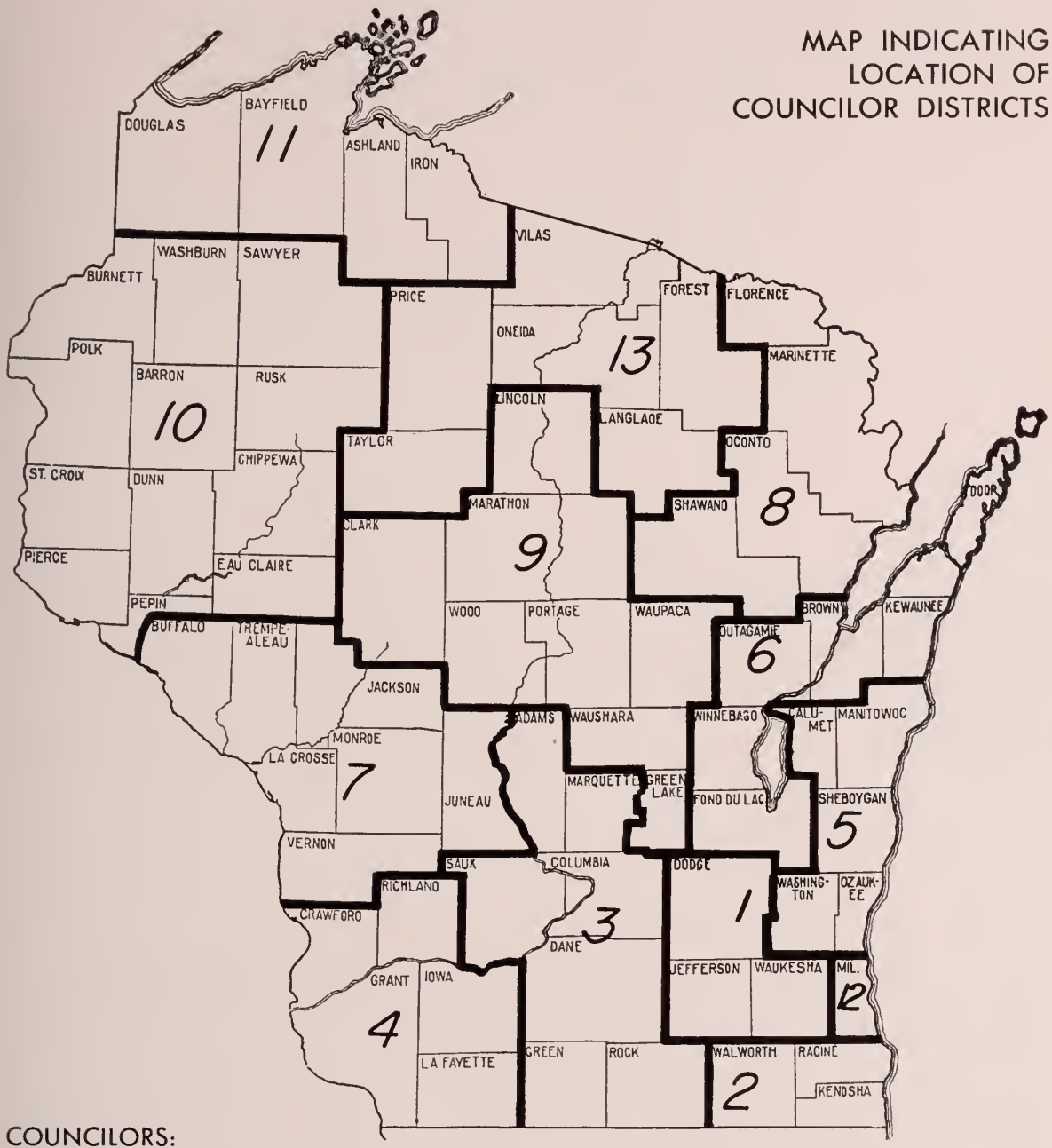

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1 South Pinckney Street

Speaker _____E. J. Nordby, M.D., Madison
2715 Marshall Court

Vice-Speaker ___N. A. McGreane, M.D., Darlington
128 East Ann Street

COUNCILORS

(J. C. Fox, M.D., La Crosse, Chairman)

DISTRICTS

First: Dodge, Jefferson and Waukesha County Societies. W. D. James, M.D., 340 Summit Avenue, Oconomowoc, 1963.

Second: Kenosha, Racine and Walworth County Societies. G. J. Schulz, M.D., 722 16th Avenue, Union Grove, 1963.

Third: Dane, Columbia–Marquette–Adams, Green, Rock and Sauk County Societies. N. A. Hill, M.D., 304 West Washington Avenue, Madison, 1961; J. H. Houghton, M.D., Wisconsin Dells, 1963.

Fourth: Crawford, Grant, Iowa, Lafayette and Richland County Societies. E. M. Dessloch, M.D., 311 South Minnesota Street, Prairie du Chien, 1961.

Fifth: Calumet, Manitowoc, Sheboygan and Washington–Ozaukee County Societies. P. B. Blanchard, M.D., 204 North Washington Avenue, Cedarburg, 1961.

Sixth: Brown, Door–Kewaunee, Fond du Lac, Outagamie and Winnebago County Societies. H. J. Kief, M.D., 104 South Main Street, Fond du Lac, 1961.

Seventh: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies. J. C. Fox, M.D. (Chairman), 212 South Eleventh Street, La Crosse, 1962.

Eighth: Marinette–Florence, Oconto, and Shawano County Societies. J. M. Bell, M.D., 516 Houston Street, Marinette, 1962.

Ninth: Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca and Wood County Societies. R. W. Mason, M.D., 650 South Central Avenue, Marshfield, 1962.

Tenth: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk and Rusk County Societies. R. C. Frank, M.D., 550 North Dewey Street, Eau Claire, 1962.

Eleventh: Ashland–Bayfield–Iron and Douglas County Societies. V. E. Ekblad, M.D., 1507 Tower Avenue, Superior, 1963.

Twelfth: The Medical Society of Milwaukee County. L. J. Van Hecke, M.D., 161 West Wisconsin Avenue, Milwaukee, 1963; G. S. Kilkenny, M.D., 2040 West Wisconsin Avenue, Milwaukee, 1963; J. P. Conway, M.D., 1800 East Capitol Drive, Milwaukee, 1961; W. J. Egan, M.D., 720 North Jefferson Street, Milwaukee, 1962; J. W. Fons, M.D., 3333 South 27th Street, Milwaukee, 1962.

Thirteenth: Forest, Langlade, Oneida–Vilas and Price–Taylor County Societies. W. P. Curran, M.D., 700½ Fifth Avenue, Antigo, 1962.

Past President ____W. B. Hildebrand, M.D., Menasha
59 Racine Street

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

A. A. Quisling, M.D. (1961) _____Madison
2 West Gorham Street

R. E. Galasinski, M.D. (1961) _____Milwaukee
3333 South 27th Street

L. O. Simenstad, M.D. (1962) _____Osceola
141 North Cascade

E. L. Bernhart, M.D. (1962) _____Milwaukee
2714 West Burleigh Street

Alternates

W. B. Hildebrand, M.D. (1961) _____Menasha
59 Racine Street

George Collentine, Jr., M.D. (1961) ____Milwaukee
3333 West Wisconsin Avenue

John M. Bell, M.D. (1962) _____Marinette
516 Houston Street

J. M. Sullivan, M.D. (1962) _____Milwaukee
161 West Wisconsin Avenue

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* Map indicating location of councilor districts, page 93.

Note: Officers, councilors, delegates, and members of Standing Committees are elected at the Annual Meeting in May.

Standing Committees—1960-1961

State Medical Society of Wisconsin

COMMITTEE ON CANCER

Paul M. Cunningham, M. D.
Chairman

Paul M. Cunningham, M.D. (1963) _____Appleton
Chairman 401 North Oneida Street
R. P. Welbourne, M.D. (1963) _____Watertown
113 North Third Street
J. R. Hoon, M.D. (1963) _____Sheboygan
1011 North 8th Street
R. R. Mataczynski, M.D. (1963) _____Superior
1514 Ogden Avenue
J. W. Boren, Jr., M. D. (1961) _____Marinette
1510 Main Street
C. W. Stoops, M.D. (1961) _____Madison
110 East Main Street
A. H. Stahmer, M.D. (1961) _____Wausau
120 Clarke Street
Ralph C. Frank, M.D. (1962) _____Eau Claire
550 North Dewey Street
G. I. Uhrich, M.D. (1962) _____La Crosse
212 South Eleventh Street
R. C. Glise, M.D. (1962) _____Richland Center
118 West Mill Street
G. A. Smiley, M.D. (1962) _____Delavan
107 North Third Street
J. J. Gramling, Jr., M.D. (1962) _____Milwaukee
324 East Wisconsin Avenue
J. F. Brown, M.D. (1962) _____Rhinelander
1020 Kabel Avenue

COMMITTEE ON GRIEVANCES

E. J. Nordby, M. D.
Chairman

E. J. Nordby, M.D. (1961) _____Madison
Chairman 2715 Marshall Court
R. E. Fitzgerald, M.D. (1963) _____Milwaukee
2218 North Third Street
K. A. Morris, M.D. (1963) _____Merrill
705 East First Street
J. D. Leahy, M.D. (1963) _____Park Falls
170 Fourth Avenue North
H. J. Belson, M.D. (1961) _____Manitowoc
904A South Eighth Street
R. R. Richards, M.D. (1961) _____Eau Claire
116 West Grand Avenue
E. D. Sorenson, M.D. (1962) _____Elkhorn
104 South Wisconsin Street
E. W. Mason, M.D. (1962) _____Milwaukee
324 East Wisconsin Avenue
R. W. Mason, M.D. (1962) _____Marshfield
650 South Central Avenue

COMMISSION ON PUBLIC RELATIONS AND COMMUNICATIONS

D. M. Willison, M. D.
Chairman

D. M. Willison, M.D. (1961) _____Eau Claire
Chairman 314 Grand Avenue East
J. E. Martin, Jr., M.D. (1963) _____Delavan
607 Walworth Avenue
D. E. Dorchester, M.D. (1963) _____Sturgeon Bay
10 North Third Avenue
G. M. Shinners, M.D. (1963) _____Green Bay
P.O. Box 739
J. S. Devitt, M.D. (1961) _____Milwaukee
944 North Jackson Street
W. J. Fencil, M.D. (1961) _____Monroe
1802 Eleven Street
C. J. Picard, M.D. (1962) _____Superior
425–21st Avenue, East
D. G. MacMillan, M.D. (1962) _____Barron
Route 1
W. E. Acheson, M.D. (1962) _____Valders
Liberty Street

COMMITTEE ON PUBLIC POLICY

A. A. Quisling, M. D.
Chairman

A. A. Quisling, M.D. (1961) ---------- Madison
Chairman 2 West Gorham Street
Robert G. Zach, M.D. (1962) ---------- Monroe
Vice-chairman 810–19th Street
J. M. Sullivan, M.D. (1962) ---------- Milwaukee
161 West Wisconsin Avenue
Earl C. Quackenbush, M.D. (1962) ---------- Hartford
14 North Main Street
D. N. Goldstein, M.D. (1963) ---------- Kenosha
723–58th Street
Norbert Enzer, M.D. (1964) ---------- Milwaukee
948 North Twelfth Street
L. J. Kurten, M.D. (1965) ---------- Racine
810 Main Street

President, ex officio
President-elect, ex officio
Secretary, ex officio

COMMISSION ON SCIENTIFIC MEDICINE

M. C. F. Lindert, M. D.
Chairman

M. C. F. Lindert, M.D. (1961) ---------- Milwaukee
Chairman 5340 North Berkeley Boulevard
R. B. Larsen, M.D. (1962) ---------- Wausau
510½ Third Street
R. W. Farnsworth, M.D. (1963) ---------- Janesville
305 Court Street
A. R. Curreri, M.D. (1964) ---------- Madison
1300 University Avenue
P. T. Bland, M.D. (1965) ---------- Westby
107 North Main Street
R. S. Baldwin, M.D. ---------- Marshfield
650 South Central Avenue
John Z. Bowers, M.D. ---------- Madison
1300 University Avenue
John S. Hirschboeck, M.D. ---------- Milwaukee
561 North Fifteenth Street

* * *

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

Chairman of the Council, Chairman
Immediate Past President
President
President-elect
Secretary

COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION

R. S. Gearhart, M. D.
Chairman

R. S. Gearhart, M.D. (1962) ---------- Madison
Chairman 621 South Park Street
C. J. Picard, M.D. (1961) ---------- Superior
425–21st Avenue, East
G. E. Collentine, Jr., M.D. (1961) ---------- Milwaukee
3300 W. Wisconsin Avenue
J. P. McCann, M.D. (1961) ---------- La Crosse
503 State Bank Building
T. H. McDonell, M.D. (1962) ---------- Waukesha
217 Wisconsin Avenue
S. L. Henke, M.D. (1963) ---------- Eau Claire
314 Grand Avenue
T. E. Boston, M.D. (1963) ---------- Hillsboro
840 Water Avenue
H. G. Bayley, M.D. (1963) ---------- Beaver Dam
124 Winn Terrace
M. V. Overman, M.D. (1962) ---------- Neillsville
John Z. Bowers, M.D., Dean, University of Wisconsin Medical School ---------- Madison
Ex officio 1300 University Avenue
John S. Hirschboeck, M.D., Dean, Marquette University School of Medicine ---------- Milwaukee
Ex officio 561 North Fifteenth Street

* * *

Council Committees

Appointments to the following committees are made by the chairman of the Council at the time of the Annual Meeting in May.

Committees of the Council (composed of members of Council):

Economic Medicine
Executive
Finance
Planning
Scientific Medicine

Council Committees:

Clinical Medicine
Disaster Medical Care
Commission on Medical Care Plans
Commission on State Departments
Editorial Board
Military Medical Service
Federal Legislation

OFFICERS OF SECTIONS OF THE STATE MEDICAL SOCIETY

Section on General Practice

President (WAGP) — R. E. Callan, Milwaukee
Secretary (WAGP) — J. A. Kelble, Milwaukee
Delegate — R. R. Richards, Eau Claire
Alternate — J. A. Kelble, Milwaukee

Section on Internal Medicine

Chairman — W. K. Simmons, Rhinelander
Delegate — L. J. Kurten, Racine
Alternate — R. L. Gilbert, La Crosse

Section on Neurology and Psychiatry

President (Wis. Psych. A.) — G. B. Tybring, Madison
Secretary (Wis. Psych. A.) — C. W. Landis, Milwaukee
Delegate — George Martin, Milwaukee
Alternate — Ervin Teplin, Milwaukee

Section on Obstetrics and Gynecology

President — D. J. Werner, Milwaukee
Vice-president — Carl D. Neidhold, Appleton
Secretary-treasurer — J. J. Boersma, Green Bay
Board of Governors — R. E. Campbell, Madison
G. S. Kilkenny, Milwaukee
R. F. Lewis, Marshfield
William Luetke, Madison
D. J. Werner, Milwaukee
J. J. Boersma, Green Bay

Section on Ophthalmology and Otolaryngology

Chairman — C. G. Kirchgeorg, Neenah
Secretary — J. W. Doolittle, Madison
Delegate — H. C. High, Jr., Milwaukee
Alternate — R. T. Schmidt, Green Bay
Councilor to National Foundation for Eye Care — S. S. Blankstein, Milwaukee

Section on Orthopedics

President — James E. Miller, Madison
Secretary-treasurer — Arch E. Cowle, Madison
Delegate — P. K. Odland, Janesville
Alternate — M. W. Nelson, Racine

Section on Pathology

President — J. M. Lubitz, Milwaukee
President-elect — F. Glassy, Marshfield
Vice-president — D. J. Carlson, Milwaukee
Secretary — R. S. Haukohl, Milwaukee
Treasurer — C. P. Erwin, Milwaukee
Delegate — J. L. Teresi, Milwaukee
Alternate — R. W. Steube, Fond du Lac
Board of Censors — J. F. Kuzma, chairman, Milwaukee
P. G. Piper, Madison
R. J. Fink, Eau Claire

Section on Pediatrics

Chairman — J. S. Vedder, Marshfield
Delegate — J. P. Conway, Milwaukee
Alternate — K. J. Winters, Wauwatosa

Section on Public Health

President — G. G. Shields, Wisconsin Rapids
President-elect — Margaret E. Hatfield, Kenosha
Secretary-treasurer — Rex E. Graber, Chippewa Falls
Delegate — J. A. Van Susteren, Sparta
Alternate — Jean C. Antonmattei, Milwaukee
Executive Committee — Those named above

Section on Radiology

Chairman — B. W. Byrne, Milwaukee
Secretary-treasurer — C. E. Schmidt, Milwaukee
Delegate — Irving Cowan, Milwaukee
Alternate — Leslie Jones, Racine

Section on Surgery

Chairman — Peter A. H. Midelfart, Eau Claire
Secretary — Norman O. Becker, Fond du Lac
Delegate — John T. Mendenhall, Madison
Alternate — Roy B. Larsen, Wausau

Section on Urology

President — D. W. Calvy, Milwaukee
Vice-president — J. W. Sargent, Milwaukee
Secretary — J. T. Hotter, Milwaukee
Delegate — J. W. Sargent, Milwaukee
Alternate — R. S. Irwin, Milwaukee

Recipients of the Council Award

Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the public.

Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

John M. Dodd, M.D.†	1930
Cornelius A. Harper, M.D.†	1930
John J. McGovern, M.D.†	1931
Louis M. Jermain, M.D.†	1931
Edward Evans, M.D.†	1931
Mina B. Glasier, M.D.†	1932
Arthur W. Rogers, M.D.†	1934
Rock Sleyster, M.D.†	1934
Olin West, M.D.†	1934
Edward A. Birge, Ph. D.**†	1935
Arthur J. Patek, M.D.†	1935
Joseph F. Smith, M.D.†	1937
Eben J. Carey, M.D.†	1938
William S. Middleton, M.D.	1938
Fred G. Johnson, M.D.†	1939
William D. Stovall, M.D.	1940
Ludvig Hektoen, M.D.***†	1941
Stephen E. Gavin, M.D.†	1944
F. Gregory Connell, M.D.	1947
E. R. Schmidt, M.D.	1949
Armand J. Quick, M.D.	1950
F. A. Stratton, M.D.†	1951
Gunnar Gundersen, M.D.	1953
W. J. Meek, Ph.D.	1953
R. G. Arveson, M.D.†	1957
Edwin B. Fred, Ph.D.	1958
Harry Beckman, M.D.	1959

** Then president of the University of Wisconsin and professor of zoology.
*** Centennial Award.
† Deceased.

Past Presidents of the State Medical Society

Mason C. Darling, Fond du Lac 1841–1847
J. B. Dousman, Milwaukee 1848, 1849
A. L. Castleman, Delafield 1850, 1851
Harmon Van Dusen, Mineral Point 1852, 1853, 1854
A. L. Castleman, Delafield 1855
John Mitchell, Janesville 1856
D. Cooper Ayres, Green Bay 1857
Clark G. Pease, Janesville 1858, 1859
E. S. Carr, Madison 1860, 1861
Solomon Blood, Rochester 1862

(No meetings held from 1863 through 1866; apparently no new officers).

Harmon Van Dusen, Mineral Point 1867, 1868, 1869
Solon Marks, Milwaukee 1870
H. P. Strong, Beloit 1871
John Favill, Madison 1872
Harmon Van Dusen, Mineral Point 1873
M. Waterhouse, Portage 1874
J. T. Reeve, Appleton 1875
J. B. Whiting, Janesville 1876
J. K. Bartlett, Milwaukee 1877
Darius Mason, Prairie du Chien 1878
Nicholas Senn, Milwaukee 1879
J. G. Meachem, Sr., Racine 1880
Ira Manley, Jr., Markesan 1881
William Meacher, Portage 1882
T. P. Russell, Oshkosh 1883
N. M. Dodson, Berlin 1884
E. W. Bartlett, Milwaukee 1885
G. M. Steele, Oshkosh 1886
S. C. Johnson, Hudson 1887
L. G. Armstrong, Boscobel 1888
J. R. Barnett, Neenah 1889
E. M. Rogers, Hartford 1890
G. D. Ladd, Milwaukee 1891
G. F. Witter, Grand Rapids, Mich. 1892
B. T. Phillips, Menominee, Mich. 1893
B. C. Brett, Green Bay 1894
Almon Clarke, Sheboygan 1895
F. W. Epley, New Richmond 1896
B. O. Reynolds, Lake Geneva 1897
William Mackie, Milwaukee 1898
Herman Reineking, Milwaukee 1899
W. T. Sarles, Sparta 1900
J. F. Pritchard, Manitowoc 1901
W. H. Neilson, Milwaukee 1902
J. V. R. Lyman, Eau Claire 1903
F. E. Walbridge, Milwaukee 1904
C. W. Oviatt, Oshkosh 1905
J. R. Currens, Two Rivers 1906
L. H. Pelton, Waupaca 1907
W. E. Ground, Superior 1908
Gilbert E. Seaman, Madison 1909
Edward Evans, La Crosse 1910
Byron M. Caples, Waukesha 1911
John M. Dodd, Ashland 1912
Arthur J. Patek, Milwaukee 1913
Charles S. Sheldon, Madison 1914
T. J. Redelings, San Diego, Cal. 1915
L. J. Jermain, Milwaukee 1916
Hoyt E. Dearholt, Milwaukee 1917
Gustave Windesheim, Kenosha 1918
D. J. Hayes, Milwaukee 1919
C. R. Bardeen, Madison 1920
H. W. Abraham, Appleton* 1921
M. A. McGarty, La Crosse 1921
S. Hall, Ripon 1922
F. G. Connell, Oshkosh 1923
Rock Sleyster, Wauwatosa 1924
Wilson Cunningham, Platteville 1925
Joseph F. Smith, Wausau 1926
Arthur W. Rogers, Oconomowoc 1927
John J. McGovern, Milwaukee 1928
Karl W. Doege, Marshfield 1929
F. J. Gaenslen, Milwaukee 1930
A. J. McDowell, Soldiers Grove** 1931
C. A. Harper, Madison 1931
Otho Fiedler, Sheboygan 1932
Reginald H. Jackson, Madison 1933
Stanley J. Seeger, Texarkana, Texas 1934
T. J. O'Leary, Superior 1935
R. M. Carter, Green Bay 1936
Stephen E. Gavin, Fond du Lac 1937
James C. Sargent, Milwaukee 1938
A. E. Rector, Appleton 1939
R. G. Arveson, Frederic 1940
R. P. Sproule, Milwaukee 1941
Gunnar Gundersen, La Crosse 1942
F. E. Butler, Menomonie 1943
R. M. Kurten, Racine 1944
Charles Fidler, Milwaukee 1945
P. R. Minahan, Green Bay 1946
C. A. Dawson, River Falls 1947
W. D. Stovall, Madison 1948
K. H. Doege, Marshfield 1949
J. W. Truitt, Milwaukee 1950
H. H. Christofferson, Colby 1951
A. H. Heidner, West Bend 1952
J. C. Griffith, Milwaukee 1953
H. Kent Tenney, Madison 1954
Arthur J. McCarey, Green Bay*** 1955
Ervin L. Bernhart, Milwaukee 1956
L. O. Simenstad, Osceola 1957
Harry E. Kasten, Beloit 1958
Jerome W. Fons, Milwaukee**** 1958
W. B. Hildebrand, Menasha 1960

* Died during term of office as president-elect.
** Resigned, because of health, prior to taking office.
*** Through April, 1955. The date of the Society's Annual Meeting, at which the president is elected, was changed from October to May during this year.
**** Resigned during term of office.

PLACEMENT SERVICE AIDS DOCTORS AND COMMUNITIES

Do you want an associate? Generalist or specialist? Then call ALpine 6–3101 or write Box 1109, Madison 1, Wisconsin.

The placement service of the State Medical Society has helped many physicians find a new assistant, found promising locations for young practitioners, and brought resident medical service to many communities without a doctor.

Here is how the placement service may be able to help you. The Society maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Usually there are 30 to 50 generalists listed and a total of 80 to 125 specialists in all categories. The Society also maintains a list of physicians and communities offering opportunities to the physician in individual, group, and other types of practice. *The Wisconsin Medical Journal* offers to carry up to one inch of advertising copy for two months without charge when the advertisement is placed by an individual member of the Society. Reasonable rates apply to advertisements by clinics and others.

Physicians who have used the placement service have described it as one of the most effective in the United States. Journal advertising, too, has proved highly successful.

One word of advice: Advise the Society of your needs as soon as possible. Overnight results have occurred, but more time usually means better results.

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	H. V. Sandin 220 Seventh W., Ashland	C. A. Grand 206–6th Ave., W., Ashland	
Barron–Washburn–Sawyer–Burnett	E. R. Krueger Hayward	Duane Flogstad Shell Lake	Second Tuesday 7:30 p.m.
Brown	E. R. Killeen 207 E. Walnut, Green Bay	Frank Urban Rm. 308, City Hall, Green Bay	Second Thursday°
Calumet	J. W. Knauf Chilton	Rafael Barajas Brillion	
Chippewa	R. L. Hendrickson 12 Third, Cornell	M. W. Asplund Bloomer	Second Tuesday
Clark	H. M. Braswell Owen	K. F. Manz Neillsville	
Columbia–Marquette–Adams	J. F. Poser Columbus	T. M. Shearer Poser Clinic, Columbus	Every Third Month 7:00 p.m.
Crawford	O. E. Satter Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	C. W. Stoops 110 E. Main, Madison	D. A. Peterson 110 E. Main, Madison	Second Tuesday Sept. through June
Dodge	W. J. Petters 404 E. Jefferson, Waupun	W. G. Richards 113 W. Maple, Beaver Dam	Last Thursday°
Door–Kewaunee	Jeffrey Brook 20 S. 1st Ave., Sturgeon Bay	Patricia Lanier 3rd & Ellis St., Kewaunee	
Douglas	J. P. McGinnis 2231 E. 5th, Superior	John Foderick 324 Board of Trade Bldg. Superior	First Wednesday°° Hotel Superior
Eau Claire–Dunn–Pepin	A. W. Hilker 314 Grand Ave., Eau Claire	G. G. Giffen Luther Hosp. Eau Claire	Last Monday
Fond du Lac	H. R. Sharpe, Jr. 92 E. Division Fond du Lac	C. M. Flanagan 80 Sheboygan Fond du Lac	Fourth Thursday°
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	E. F. Freymiller Boscobel	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	D. E. Mings The Monroe Clinic, Monroe	P. H. Marty New Glarus	
Green Lake–Waushara	Dowe Cupery Markesan	David Sievers 118 Spring St., Berlin	Last Thursday, every other month starting in Jan.

° Except June, July and August. °° Except July and August.

(Continued on next page)

List of Officers and Scheduled Meetings of County Medical Societies *(Continued)*

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	W. D. Hamlin Mineral Point	E. J. Hobler Mineral Point	First Thursday following first Monday
Jefferson	Roland Liebenow Lake Mills	John H. Becker 115 N. Third, Watertown	Third Thursday*
Juneau	V. M. Griffin Hess Clinic Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	William Swift 723–58th, Kenosha	D. B. Horsley 6530 Sheridan Rd., Kenosha F. John Shannon, Ph.D., Exec. Secy. 416–73rd Street, Kenosha	First Thursday* Elks Club
La Crosse	Robert W. Ramlow 1836 South Ave., La Crosse	Geo. B. Murphy, Jr. 1836 South Ave., La Crosse	Third Monday
Lafayette	L. L. Olson Darlington	D. F. Ruf Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth, Antigo	J. E. Garritty Antigo	First Monday
Lincoln	E. C. Jarvis Tomahawk	H. G. Adams 110½ W. Wisconsin Tomahawk	
Manitowoc	N. S. Davis 104 N. 8th, Manitowoc	R. G Strong 821 Washington St. Manitowoc	Last Thursday
Marathon	R. B. Larsen 510 Third St., Wausau	T. C. Burr, Jr. Fifth and Jefferson Wausau	
Marinette–Florence	P. R. McCanna College Avenue, Appleton	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	James M. Sullivan 161 W. Wisconsin Ave. Milwaukee	I. J. Ricciardi 1823 N. 81st St., Milwaukee Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milwaukee	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	J. R. Culver 150 N. Main, Oconto Falls	F. W. Klutzow Gillett	
Oneida–Vilas	F. A. Cline 123 N. Stevens Rhinelander	W. K. Simmons 1020 Kabel, Rhinelander	Monthly
Outagamie	G. A. French 601 W. College Appleton	F. M. Hauch 519 W. College Appleton	Third Thursday* Elks Club
Ozaukee	R. H. Dorr Belgium	R. F. Henkle 549 W. Grand, Pt. Washington	
Pierce–St. Croix	F. O. Grassl 106 S. Main, River Falls	P. H. Gutzler River Falls	Third Tuesday
Polk	D. M. Ericksen St. Croix Falls	L. J. Weller Osceola	Third Thursday 7:00 p.m.
Portage	G. H. Anderson 538 Main Stevens Point	R. H. Bickford 1505 Main, Stevens Point	
Price–Taylor	W. W. Meyer 410 S. Second, Medford	J. D. Leahy, Acting Sec'y. 170 N. 4th Ave. Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	J. D. Postorino 1701 Douglas Ave. Racine	Ernest MacVicar 420 7th St. Bldg., Racine Mr. James Congdon, Exec. Secy. 205–6th St., Racine	Third Thursday
Richland	D. H. Hinke 118 W. Mills Richland Center	L. M. Pippin Richland Center	First Thursday Richland Hospital
Rock	W. J. Mauermann 419 Pleasant, Beloit	R. L. Chancey 1146 Grant Beloit	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	J. T. Siebert Baraboo	R. G. Knight Reedsburg	Second Tuesday*
Shawano	W. J. Von Ruden 139 N. Main, Shawano	A. J. Sebesta Shawano	Third Wednesday
Sheboygan	Harris A. Weisse Plymouth Hosp., Plymouth	J. F. Kovacic 708 St. Claire Ave. Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	R. M. Thurow 221 Main St. Black River Falls	J. H. Noble 1109 Harrison Black River Falls	Fourth Tuesday
Vernon	W. N. Otterson Westby	R. B. Balder, Jr. 840 Water Ave. Hillsboro	Last Wednesday
Walworth	H. M. Levin Delavan	R. J. Rogers Elkhorn	Second Thursday*
Washington	V. V. Quandt 57 S. Main, Hartford	R. F. Sorensen 139 S. 6th Ave. West Bend	Fourth Thursday
Waukesha	T. H. McDonell 217 Wisconsin Ave., Waukesha	Philip Wilkinson 114 E. Wisc., Oconomowoc	First Wednesday
Waupaca	J. W. Monsted New London	H. S. Caskey Clintonville	
Winnebago	S. R. Beatty 117 N. Commercial, Neenah	D. J. Ryan 117 N. Commercial, Neenah	First Thursday
Wood	L. C. Pomainville 521 8th St. S. Wisconsin Rapids	J. R. Heersma 650 S. Central, Marshfield	Four times a year

* Except June, July and August.

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(continued on next page)

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CHEMICAL TESTS FOR INTOXICATION

Chemical tests for intoxication are legal in Wisconsin.

Samples of breath, blood, urine, or saliva may be taken and analyzed to determine the sobriety of a person operating a vehicle or handling a firearm. The results of the analyses are admissible as evidence in court cases and other legal proceedings.

Consent—Legal counsel for the State Medical Society advises that under Wisconsin law consent is required before a physician may take a blood sample for the purpose of determining alcohol content in cases of alleged drunkenness.

Sobriety will be deemed proved—if a sample taken within two hours of the event shows only 5 one-hundredths of 1% or less by weight of alcohol in the blood. Other evidence to the contrary may affect or change the presumption, however.

Intoxication will be presumed—if the alcohol concentration is 15 one-hundredths of 1% or more. Other contrary evidence may upset this presumption.

No presumption is created—by alcohol concentrations between these two ratios, or if the sample was taken more than two hours after the event. However, an expert witness may testify that even these tests prove sobriety or intoxication.

Reference: Section 325.235, Wisconsin Statutes, 1959.

The President's Page

APPRECIATION

AS WE PASS from this year of great achievement to the mysteries of the year ahead, it gives me great pleasure, and no known amount of comfort, to know that our destinies are in the hands of those who are well qualified and well able to guide and direct us in the right paths.

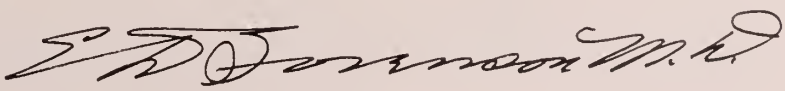
It has been my privilege in the past years to be associated in some manner or degree with the organization and function of our State Medical Society, and I am particularly proud and humble that it is now my honor to serve you as your president. In my service as a humble servant, it has also been my privilege to meet and to learn to know a great many doctors that make up the State Society. Friends I have made, I know. Enemies? I do not know, but I greatly appreciate the fact that there has been exemplified, at least to me, a great cooperation of effort, and a willingness to serve in any capacity that has been indicated. It has been my grateful experience that we have many loyal doctors in our Society. Many have proven it by their acts, and too much credit or praise cannot be given them. They do not look for fame.

There is another segment of our fraternity, that although they are not practitioners of medicine, cannot be given too much praise. That is our staff. From the Secretary and his assistants, and their assistants, down to the last stenographer. Never have I seen more loyalty, and more unselfishness in any organization than is exemplified by these wonderful people.

They may be, and are, called upon any day of the week, or any hour of the day, and willfully give of their time and their pleasure, that they may serve.

There is exemplified a devotion to duty, to an ideal, to a destiny of which they surely must feel themselves a part. They sacrifice home life, their families, their friends, their desires and their moments of joy, to serve you and I. May God bless them and keep them steadfast in the pursuit of these ideals.

I hope and trust that every member will come to our —"Your"— home during this coming year and visit and learn to know your staff. They will heartily welcome you at any and all times, and you will leave with a finer appreciation of the many things that are accomplished by them and for you.



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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Spine Tingling Cheek

In case you haven't noticed, doctor, you have "demonstrated at the community level, a growing capacity to cooperate in the mutual problem of public health" with "doctors" of chiropractic!

That is the fantastic allegation of the International Chiropractors Association which resolved in convention, to urge the American Medical Association to encourage "speedy enactment of laws governing the practice of chiropractic" in the four states which do not license this nonsense.

On the surface the chiropractors' resolution and its ridiculous statements is nothing more than amusing. Certainly there has been no cooperation between chiropractors and doctors of medicine on the community level or on any other level, and just as certainly the AMA is not going to endorse any attempt to dignify a racket such as chiropractic with licensure. But beneath the surface, there seems to be a shrewd effort to set up a David-Goliath situation with big, bad "Organized Medicine" as the Goliath.

To poorly informed laymen, legislators, editors and other molders of public opinion, the resolution suggests that chiropractic is a science competitive with medicine. It implies that this science is being suppressed by "Organized Medicine" (for competitive reasons), and even though cooperation is possible, underdog chiropractic is being denied the people, to the detriment of the public interest. The fact that legal recognition is denied chiropractic in only four states seems to give evidence that "Organized Medicine" is fighting a losing battle and the underdog is finally coming into his own. To the average American there is nothing so appealing as an underdog—good, bad or indifferent.

The political efficiency of the cult of the chiropractors is neither recent nor inconsiderable. Using a mish-mash of lofty language, pseudo-science and popular misconceptions, chiropractors have achieved licensure in 46 states. They have perverted the policy of such influential organizations as the VFW and the American Legion. The legislature of Wisconsin passed a statute licensing chiropractors in 1925, thus giving them status it has had the good sense to deny other practitioners of quack health cults.

The resolution of the International Chiropractors Association frankly recognizes doctors of medicine as enemies of quackery—as a "decisive factor" in restraining quick-buck artists in the public health field. The representations of cooperation between doctors and chiropractors is a bare-faced lie, just as the offer of benefits to the public from legal recognition of the cult is a fraud.

It is to be fervently hoped that the resolution will mislead none who read it. Its effect on the policy of the AMA will be nil. However, the very temerity of an organization of charlatans ought to suggest that more positive action should be taken to combat them. In Wisconsin, we should repeal the legislation that licenses them, and make their practice illegal—with penalties for clandestine practice. The AMA should start a movement to remove their legal sanction in the states where they enjoy it and take the offensive in fighting these cultists wherever they appear.

But licensed or not, chiropractors will enjoy the confidence and patronage of uninformed, desperate people who have never gotten over their superstitious belief in magic. These unfortunates need the protection of laws; even more, they need the enlightenment of education, and it is the duty of organized medicine to provide that education.

To oppose chiropractic with the contempt and disdain it deserves is an easy thing. To oppose it effectively, we must educate and we must legislate.

Some day chiropractic will stand in the ranks of such "sciences" as astrology, phrenology, numerology and tea-leaf reading. To hasten that time, the public must know the difference between medicine and such quackeries as chiropractic. Legitimate medical service must give the lie to the representations of quack organizations. The place to begin is in the public press, and we must never stop until chiropractic naturopathy and all the other quack practices are legally and popularly as disreputable as fortune-telling.

The only way chiropractors can cooperate with doctors of medicine in the public interest is by going out of business.

Hard Look at the Record

This year marks the twenty-fifth anniversary of the passage of the Social Security Act by both houses of Congress, and we can, in retrospect, judge how well this New Deal experiment has developed into an institution. And this phenomenon contains significance that the medical profession must not overlook.

Those who lived through the parlous days of the early Thirties vividly remember the dire prophecies that accompanied the inauguration of old age insurance and its companion legislation, unemployment compensation. Organized business insisted that the Social Security Act would facilitate ultimate "socialistic control of life and industry." It was pointed out that old age and survivors' insurance was actually not insurance and that the funds accumulated were at the mercy of any succeeding Congress. "The lash of the dictator will be felt," shouted one congressman.

The official position of the American Medical Association in 1935 was not against the Social Security Act as such, but opposed certain portions dealing with the delivery of medical care. It is still engaged in fighting against extension of social security mechanisms to the rendition of medical care, an action in which it is joined by many other groups of society.

The operation of the Social Security Board has been succinctly described by Arthur M. Schlesinger, Jr., in his *The Coming of the New Deal.* "No government bureau," he writes, "ever directly touched the lives of so many millions of Americans—the old, the jobless, the sick, the needy, the blind, the mothers, the children—with so little confusion or complaint. And the overhead costs for this far-flung and extraordinary operation were considerably less than those of private insurance." After 25 years, Social Security has been extended to cover almost every category of employed person, with one major exception.

In this quarter of a century the country has not been socialized or sovietized; the lash of the dictator has not been felt, individual responsibility, initiative, thrift and all the other homely virtues have not been destroyed. Indeed, bank deposits are at an all time high, and more small investors hold shares of American industry than ever before. At the same time, the assurance of retirement income and estate equity has enabled millions of American workers to look to their twilight years with confidence and dignity.

The predictors of doom were wrong and the howlers of socialism were wrong. Twenty-five years have demonstrated, to the satisfaction of most people, the value of Social Security.

Organized medicine has been frequently and wrongly accused of opposition to the establishment of Society Security. This should not frighten us out of our obligation to state our opposition to measures we believe are unwise. The United States is a democracy, and experience has shown that effective social progress is frequently shaped between the hammer of proposition and the anvil of opposition. We must continue to fight for what we, as Americans, believe is best for our country.

There is one important lesson to be drawn from the history of the opposition to Social Security. When medicine opposes a measure, we must oppose it for its own sake. It was manifestly ridiculous for some to characterize the Social Security Act as "socialistic" or "communistic." It isn't and it wasn't. Use of such epithets only generated heat where light was necessary. If a measure is bad, it is bad for reasons which are themselves valid, and not because it is socialistic. If a measure is wise, it is wise regardless of who proposes it.

When we oppose government control of medicine, let us use logic as our weapon. If we are right, our logic has persuasive power. To resort to name-calling or to play on the fear of socialism or communism is to betray the weakness of our case.

There's many a hard fight ahead as the government becomes more intimately involved in the field of general welfare. Let us remember the example of opposition to the Social Security Act and take from it the understanding to meet new challenges with wisdom.

Doctors—Past and Present

We visited the other day with a doctor friend who was our neighbor in a northern city. The doctor, a first-class physician and surgeon, suggested during the conversation that the public today does not hold the medical profession in the same warm regard of yesteryear.

The clamor for socialized medicine and the gripes sometimes made against doctors perhaps can be traced to changes that have come to the profession in a generation or two.

Time was when a country doctor made his diagnosis in the family bedroom and would come in the middle of the night to look over a case of measles. Today a large percentage of medical men will not accept house calls at all.

Some people still remember how old-time doctors bucked blizzards in a horse and buggy or hauled themselves bone-tired to a confinement in the wee hours of the night.

It is understandable how this kind of attention would serve to endear the physician to the family. Something has indeed been lost in the substitution of the antiseptic office or clinic for the family home as a diagnostic center.

And those old enough to remember the "work horse" doctors who seemed never to have slept are still appalled at the effrontery of clean-shaven young medical men who may take a day off during the week to play golf.

Medicine, like everything else, has changed in thirty or forty years. There are still a few around who practice it the old way, but we imagine that for the young intern starting out today it's a business that demands a regimen far different than in the old days.

Doctors, like everyone else, have followed the trend of working fewer hours while endeavoring to keep their income at a standard commensurate with the profession. Top surgical specialists in major hospitals have a schedule of hours that would make a banker blush, but who can argue that a man should work ten hours a day removing gallbladders?

The house call situation, which is the main bone of contention in most small towns, is easily explainable from the doctor's viewpoint. With the shortage of qualified physicians, calls to the home are almost out of the question. Times have changed from the days when a physician "made his rounds" out in the country instead of from bed to bed in a hospital. With so much time wasted traveling around a doctor today could not see half the patients he can by having them visit his office, the clinic or the hospital for examination.

And doctors who take a day off in the middle of the week have a good argument in the fact that the rest and relaxation will make them better able to perform in an exacting and demanding profession. It is true that country doctors once removed the ap-

pendix on a kitchen table by light of a kerosene lamp, but almost anyone would rather submit to a knife held by a reasonably refreshed technician, better trained and no less dedicated than his predecessors—even though he does play golf in the low 80's.

Readers should not be misled into believing that present-day doctors are not given to long hours and hard work. Even in the small community of Boscobel the lights may be seen burning at any hour in the operating room of Memorial hospital.

But by and large the profession has changed, and in the evolution the warm bond that existed between the patient and the doctor who would always come to the house in the night does not exist any more.

In any field of endeavor that yields to progress, something is gained and something is lost. Perhaps doctors need to be better public relations men to gain public understanding of the fact that medicine is better today—even without house calls, buggies and the bucking of blizzards.—*Reprinted from the* BOSCOBEL DIAL, *September 22, 1960.*

Good Business

The observance of "National Employ the Physically Handicapped Week" recently emphasized civic desirability of hiring persons with physical limitations. Displaying a picture of the Statue of Liberty and bearing the message "Equal Opportunity—Hire the Handicapped", posters appeared in almost every community in the nation enlisting the support and interest of those who are able to give employment to partially disabled workers.

The appeal to democratic inclinations is a cogent one, but it doesn't compare to the compelling force of this one frequently attested fact: it is just good business to hire the handicapped. In office work, in light factory duties and in many other capacities, hard-headed employers have found that handicapped workers frequently turn in better performance records than the non-handicapped employee.

The number of the physically handicapped workers is constantly growing. Accidents, disease, war, and just the process of being born are swelling the ranks of the disabled. In Wisconsin it is estimated that more than 750,000 people are disabled. The State Vocational Rehabilitation Division, the Veterans Administration and the Wisconsin State Employment Service know who they are and attempt to place them in commerce and industry.

Seldom is the opportunity for private gain and public service so neatly congruous for the employer. To obtain a qualified, competent worker and to remove a name from the roles of public assistance is a worthy project for all clear-thinking citizens.

Although the nation's attention was directed to the employment of handicapped workers for only one week, the spirit of the week is progressive and should be advanced throughout the year wherever possible.

THREE NEW MEDICAL FILMS ANNOUNCED BY EATON

Three new medical motion pictures have been added to the film library of Eaton Laboratories Division, The Norwich Pharmacal Company, Norwich, N. Y., and are now available to the medical profession.

The films, all 16 mm. sound and color, are:

"The Repair of Vesicovaginal Fistula: Transperitoneal Transvesical Approach", by John W. Dorsey, M. D., and Carl G. Peterson, Jr., M. D. of the U.C.L.A. School of Medicine and Harbor General (L. A. County) Hospital, Los Angeles, California. The film runs 15 minutes.

"Bladder Flap Ureteroplasty", by Michael K. O'Heeron, M. D., James R. Fish, M. D., and Julio Pow Sang Yui, M. D., of the Department of Urology, Baylor University College of Medicine, Houston, Texas. The film runs 30 minutes.

"Combined Vaginal Neurectomy and Suspension of the Uterus / A Physiologic Approach to the Chronic Pelvic Congestion Syndrome", by A. A. Wexler, M. D., of the Department of Obstetrics and Gynecology, Baylor University College of Medicine and Methodist Hospital, Houston, Texas. The film runs 18.5 minutes.

These new films can be obtained for showing to medical groups by writing to Paul F. MacLeod, M. D., Medical Director, Eaton Laboratories Division, The Norwich Pharmacal Company, Norwich, N. Y.

one of a series

Medical Stamps

FRIEDRICH R. KREUTZWALD (1803–1882)

A friend of Robert F. Faehlmann (q.v.) who had a part in posthumously publishing his collection of Estonian Folklore "Kalevipeog."

Friedrich Reinhold Kreutzwald came from a poor family. Taught in public schools while studying medicine in St. Petersburg. Practiced in Dorpat for sometime and in Voru. Interested in native languages, published an Estonian grammar and had a part in publishing a collection of folklore. Is portrayed on stamp more because of his literary efforts than as a physician.

These stamps issued in 1938 to commemorate the centenary of the Estonian Philosophical Society, #140–141.

VLADEN DJORDJEVIC (1844–1919)

Yugoslavian, surgeon, educator. Founder of Serbian Medical Society. Yugoslavia shows him on stamp RA2.

• • •

ACKNOWLEDGMENT: Reproduced by permission of Oscar Gottfried, New York City, author of "Doctors Philatelic," bibliography of nearly 300 illustrative medical stamps, which is available at $3.00 from The New York Physician, 1440 Broadway, New York 18, N. Y.

• • •

Physicians interested in obtaining medical stamp displays for exhibit purposes, write Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin.

So You're Going Abroad . . . . . HEALTH HINTS FOR TRAVELERS

The Department of Health, Education, and Welfare, Public Health Service, has a new leaflet out entitled "So You're Going Abroad . . . Health Hints for Travelers." This leaflet is a companion to a series giving immunization requirements for specific areas of the world which the Division has prepared. One of the series entitled "Health Information for Travel in Europe" has been released. The others are entitled:

1) PHS–748–B, Health Information for Travel in Mexico, Central and South America, and the Caribbean;
2) PHS–748–C, Health Information for Travel in Asia, including Japan, Indonesia, and the Philippines, and in Australia and New Zealand; and
3) PHS–748–D, Health Information for Travel in Africa, including Madagascar and Neighboring Islands.

These will be released for distribution later.

Additional copies of the leaflet may be obtained from the Superintendent of Documents, Government Printing Office, Washington 25, D.C., at 5¢ a copy. There is a discount of 25 per cent for 100 or more copies delivered to the same address.

Medical Genetics Teaching Film

The National Foundation is pleased to announce the availability of a new teaching film, MEDICAL GENETICS—PART I.

The film was prepared by Victor A. McKusick, M.D., and his associates in the Department of Medical Genetics, The Johns Hopkins University School of Medicine. It covers (1) historical development, (2) the physical basis of inheritance, (3) some chromosomal abnormalities in man.

The film may be obtained free of charge, except for return postage and insurance, by writing the Department of Professional Education. Three weeks' advance booking is requested.

New Mead Johnson Filmstrip

A new filmstrip of Mead Johnson's Management Principles in Medical Practice series, entitled "Public Relations—the Doctor and His Communities," defines the physician's primary communities as (1) his family, (2) his office, (3) the neighborhood, (4) the hospital, and (5) professional societies. It is the latest in the series of ½-hour animated filmstrips designed to assist young physicians in setting up and managing a practice. The strips are shown on request to medical schools, hospital teaching centers and other interested medical groups by specially trained Mead Johnson representatives.

THE MEDICAL
FORUM

Expect Public Health In Legislative Spotlight With Kerr–Mills Implementation A Key Issue

With the opening of the Wisconsin Legislature, public health looms as one of the major topics for the 1961 session.

Although relatively few health bills have been introduced since the opening of the session on January 11, it is apparent that several major and possibly controversial measures are headed for introduction.

HOW CAN YOU HELP?

Dr. A. A. Quisling, chairman of the Committee on Public Policy, points out in this issue of the *Forum* the ways in which you can aid your legislators by active support and interest. Read his comments.

The spotlight is expected to be turned on two chief health problems in the next few months:

1. **Enabling legislation to permit Wisconsin to take advantage of Federal grants-in-aid under the Kerr–Mills bill providing surgical–medical and hospital care for the near-needy aged over 65.**
2. **Reorganization of the state's local public health officer system and encouragement for county, multiple-county and city-county health departments.**

Although Wisconsin already offers its indigent citizens of any age one of the most complete health care programs in the nation, new state laws are needed if Wisconsin is to accept some $3,000,000 in Federal grants available for a new program of assistance to the near-needy elderly.

STATE CAPITOL
Hoppers Begin To Fill

Governor Nelson has asked the State Department of Public Welfare to present some proposals to accomplish this.

The State Medical Society is discussing several alternatives with the Department.

It is estimated that some 300,000 persons over age 65 in Wisconsin are potentially eligible for benefits, depending upon whether the legislature authorizes state-matching funds and how it sets up the eligibility requirements. Persons receiving Old Age Assistance benefits may not be covered by the new program.

Total cost of the program depends upon who is eligible and what types of care are covered under the plan, if Wisconsin goes ahead. Estimates of total cost, including federal matching funds, range from about $6 million to $25 million per year.

GOV. GAYLORD NELSON
Asks For Proposals

LEGISLATIVE GUIDE

In this issue of the *Forum* are tables and maps listing Wisconsin's lawmakers, both at the statehouse in Madison and the capitol in Washington. They will serve as handy guides during the legislative sessions.

Local public health organization in Wisconsin has been under study for nearly a year by the Legislative Council. It recently made four proposals, only two of which passed the full Council.

Two bills which have been introduced with the recommendation of the Council are:

A. **Bill 2, S.** This bill would:

1. Eliminate all township health officers.
2. Abolish the county health committee and replace it with a county health commission which has jurisdiction over all areas in the county not served by a city or village board of health.
3. Any village or city within the county may have its own board of health. However, if it does not provide for such a board of health within 60

(Continued on next page)

Expect Public Health In Legislative Spotlight

(Continued from page 111)

days of the first meeting of its governing body after the effective date of this law, the county health commission will assume public health jurisdiction over the village or city.

4. The county health commission can be constituted in one of two ways:
   a. Not less than 5 members of the county board plus the district health officer, ex officio, or
   b. Not less than 5 nor more than 7 members which must include 1 from the county board, 2 practicing physicians, 1 dentist and the remainder county residents with an interest in public health; plus the district health officer, ex officio.
5. The commission shall employ a health director and may employ sanitarians and public health nurses. The health director is in effect the county health officer and among his duties are those of the ordinary health officer, including supervision of nurses and sanitarians employed by the county health commission. The health officer may be full or part time but if the latter the county health commission must arrange for the advisory services of a physician. The county health director need not be trained in public health.
6. A village or city which has its own board of health will nevertheless contribute, as it does now, to the cost of county services through its share of county taxes.

B. **Bill 3, S.** This bill provides that whenever a county health department is established the boards of health and health officers in all towns, cities and villages as well as the county health commission shall be abolished and the jurisdiction over all shall be assumed by the county health department. The only exception is for villages and cities having a full time health department with a full time health officer.

The purpose of the wording in Section 1 of this bill is to clarify the meaning of a full time health department and who is a "participating" city or village.

This bill eliminates a portion of the present enabling law which requires that no part of the cost of operation of a county can be levied against any property maintaining a full time health department.

Although rejected by the Legislative Council, two other bills may still appear before the legislature:

C. **Proposed Bill LRL 72.** This bill creates a Permanent Advisory Committee on Local Public Health Services. It advises the State Board of Health on the administration of laws pertaining to public health, recommends standards for local public health departments and reviews local public health organization and programs. The committee is to consist of the state health officer (or his representative) and 15 members who have a special in-

(Continued on next page)

How the Physician Can Help In Legislative Action

DR. QUISLING

Dr. A. A. Quisling, Madison, chairman of the State Medical Society's Committee on Public Policy, points out that the legislator, whether state or national, needs and desires the active interest and support of his constituents. In the sometimes highly technical field of medicine and public health, Doctor Quisling emphasizes, the need for advising and counseling with legislators is even more important.

Doctor Quisling offered the following suggestions to physicians in their role as citizens interested in good government and sound public health:

1. **A strong state medical society legislative committee is fine, but the legislator is most interested in the kind of interest he gets from his home community.**
2. **Aside from personal face-to-face visits, the most effective way to reach the legislator is through letter writing. The letter should be brief, friendly, and express the reasons why the writer favors or opposes a particular bill. Be helpful, constructive and friendly . . . not dictatorial, abrupt or tactless.**
3. **Legislators have a responsible and often difficult task to perform. When they do it well, thank them.**
4. **Postcards, especially if mimeographed, have little influence on any legislator. The same is true of telegrams, except of course, as a last-minute measure. Telephone calls are time consuming, and unless received from one he knows personally, may irritate rather than persuade. However, if the issue is immediate, telephoning may be the only reasonable avenue.**
5. **Enlist the support of friends and others who may support medicine's viewpoint when they know how a particular piece of legislation will affect them.**

Members of the State Medical Society will be kept informed of the progress of bills affecting medicine and public health through bulletins, the *Wisconsin Medical Journal*, and reports to county medical society officers.

SMS Committee Favors Bills On Public Health Organization

(Continued from page 112)

terest in public health and civic interests representing various segments of the population.

D. **Proposed Bill LRL 199.** This bill would provide state aid in the amount of $2,000 annually to each county, city or village which employs a full time health officer meeting the training and experience requirements of the State Board of Health.

The State Medical Society has since 1946 favored legislation to expand full time public health departments on a county, multiple-county and city-county basis.

At a recent meeting of the Legislative Council, Dr. N. A. Hill, Madison, chairman of the Committee on Economic Medicine of the State Medical Society, presented the following statement of this committee composed of Drs. J. P. Conway, Milwaukee; P. B. Blanchard, Cedarburg, J. H. Houghton, Wisconsin Dells; Gordon Schulz, Union Grove, and James C. Fox, La Crosse, ex officio:

"Improved public health for the people of Wisconsin has long been a major purpose of the State Medical Society. It has repeatedly demonstrated support for legislation designed to provide Wisconsin with the type of public health organization necessary to achieve this goal.

"Specifically, in October, 1946, the House of Delegates of the State Medical Society of Wisconsin placed itself on record 'urging complete population coverage with modern public health organizations on a county, joint county or district basis.'

"A committee of the Society has closely followed the efforts during the past several months by the Public Health Committee of the Legislative Council to develop recommendations to improve local public health organization in this state.

"It is our belief that Proposed Bills LRL 72, 199, 73 (now Bill 2, S.) and 94 (now Bill 3, S.), if enacted, would be a sound and significant step in support of the Society's position as expressed in 1946. We support these bills in principle and encourage a favorable reaction by the Legislative Council."

Several other measures affecting medicine and public health are reported in the offing:

1. **Radiation Hazards**—The control of radiation hazards is the subject of several proposals being studied by the State Board of Health, the Industrial Commission and the Governor's office.
2. **Economic Poison Control**—Several deaths of children last year from accidental ingestion of farm and crop poisons has prompted a Legislative Council proposal for licensing of all sellers and users of economic poisons in Wisconsin.
3. **Chiropractic**—It appears that for the first time the two major Wisconsin chiropractic associations may join together in promoting legislation to make chiropractic services available to beneficiaries of Workmen's Compensation upon direct request of the employee.
4. **Home Nursing Care**—The Bureau of Public Health Nursing of the State Board of Health is seeking legislation permitting cities and counties to collect fees for home nursing care provided by their health services. Fees would be established on the basis of ability to pay.

There has also been discussion on Capitol Hill of a bill providing minimum standards for ambulance equipment and first aid training of the driver and assistant. The chiropodists apparently will seek to obtain legislative recognition of their desire to be known as "podiatrists." Some effort seems likely, also, to extend or alter current laws permitting the licensing of graduates from unapproved foreign medical schools. The present law expires July 1, 1961.

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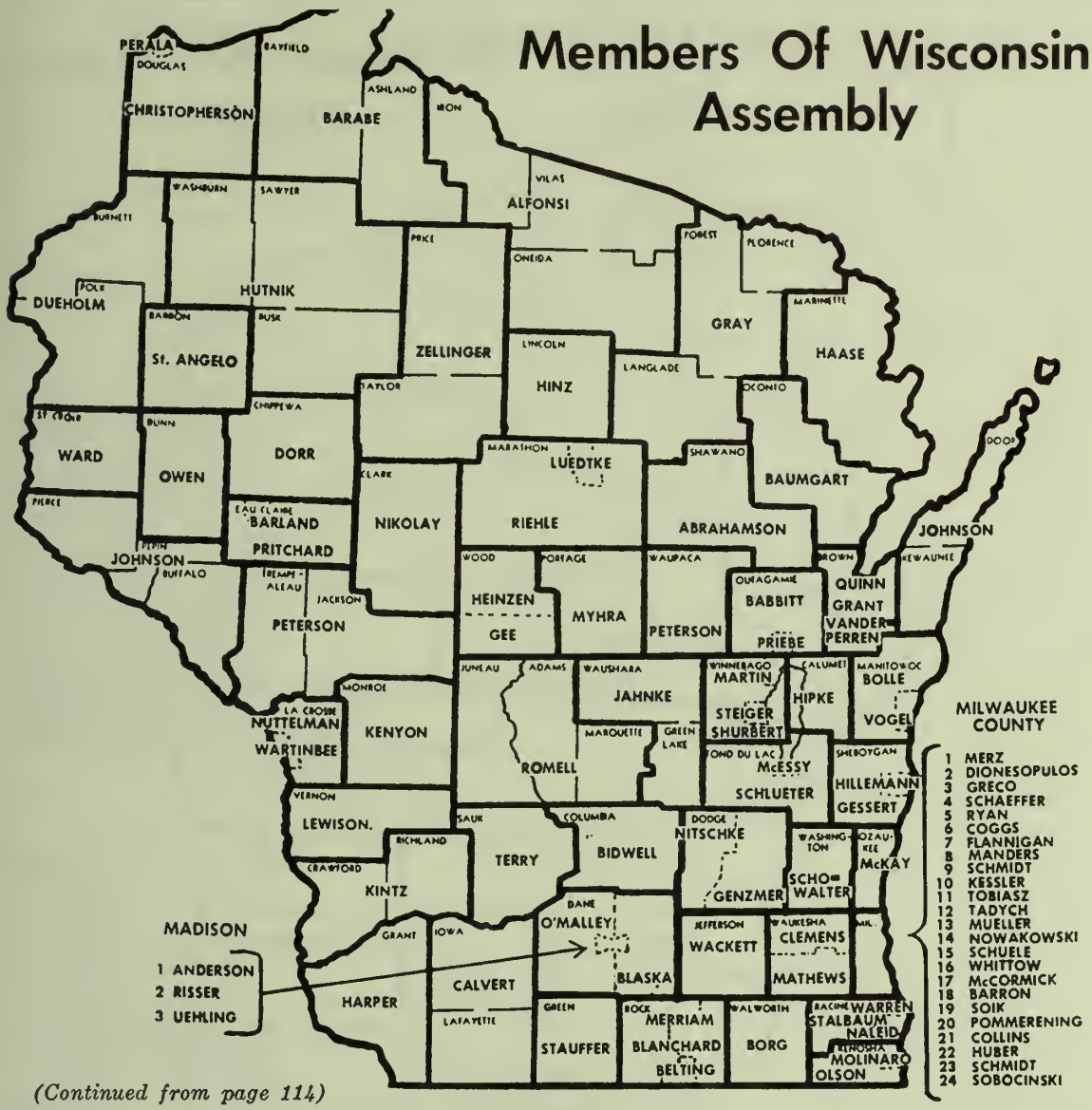

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Director Named for Maternal-Child Health

Appointment of Dr. James L. Wardlaw, Jr., Florida, as new director of the State Board of Health's Bureau of Maternal and Child Health has been announced by Dr. Carl N. Neupert, State Health Officer.

Doctor Wardlaw succeeded Dr. Amy Louise Hunter on January 3. Doctor Hunter retired after more than 25 years' service as director of Maternal and Child Health.

DOCTOR HUNTER
Twenty-five Years' Service

The new director has been with the Florida State Board of Health for the last 11 years. He received his medical education at New York University and holds a master's degree in public health from the University of North Carolina.

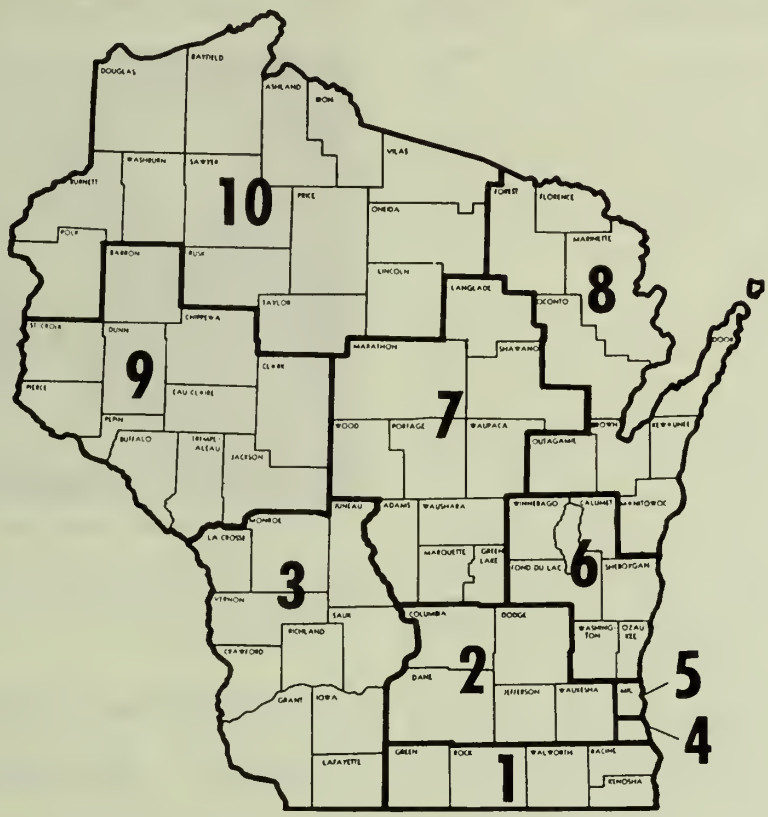
DOCTOR WARDLAW
Assumes New Position

A veteran of World War II, Doctor Wardlaw has served as director of the county health department at Key West, director of the Florida State Board of Health's field advisory staff, and as school health consultant and acting director in the board's Bureau of Maternal and Child Health. He also served on temporary assignment to Uruguay developing a Division of Local Health Services in that country.

Doctor Wardlaw is a fellow of the American Public Health Association, chairman of the health officers' section of the Florida Public Health Association, a member of the American Association of Public Health Physicians and the Association of Military Surgeons, and a diplomate of the American Board of Preventive Medicine.

Upon her retirement, Doctor Hunter had served in her position longer than any other active director of maternal and child health in the country. She has headed the division since April 1935.

Members Of Congress



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4	**Clement J. Zablocki (D)** 3245 W. Drury Lane Milwaukee
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7	**Melvin R. Laird (R)** 313 E. Third Street Marshfield
8	**John W. Byrnes (R)** 414 E. Walnut Street Green Bay
9	**Lester R. Johnson (D)** Black River Falls
10	**Alvin E. O'Konski (R)** Mercer

Consider Study Of Automobile Crash Injuries

Members of seven Wisconsin organizations, interested in highway safety, met December 7 at the State Medical Society building in Madison with Richard Braisted, representing the Automotive Crash Injury Research of Cornell University, New York, to discuss a study of auto accident injuries in Wisconsin.

Such a study could help reduce injuries suffered by persons in auto crashes, and could help somewhat to reduce auto accidents, Braisted said. The data would be used mainly in bringing about redesign of autos to eliminate features which contribute to injury when an accident occurs.

Serving as hosts for the meeting were the members of the Division on Safe Transportation of the Commission on State Departments of the State Medical Society. Dr. Dayton **Hinke**, Richland Center, is chairman, and members are Drs. James L. **Weygandt**, Sheboygan; Richard **Wixson**, Madison; Richard B. **Windsor**, Sheboygan; George **Anderson**, Stevens Point; and Milton **Trautmann**, Prairie du Sac. Dr. T. W. **Tormey**, Jr., Madison, also represented the medical society.

Exact details have not been set, but will be proposed by the Cornell group in the near future. The meeting was to ask the cooperation of the state groups, and the decision will await a blueprint from the Automotive Crash Injury Research on exactly what is feasible for Wisconsin.

A PROPOSED CRASH INJURY STUDY for Wisconsin was a topic for discussion by, left to right: James L. Karns, commissioner, Wisconsin Motor Vehicle Department; Dr. Dayton Hinke, Richland Center, chairman of the State Medical Society's Division on Safe Transportation of the Commission on State Departments; and Richard Braisted, New York, representing the Automotive Crash Injury Research of Cornell University.

Committee Formed To Study Medical Student Recruitment

A Committee on Medical Student Recruitment has been formed by the Commission on Hospital Relations and Medical Education of the State Medical Society.

Named to the new committee, which will seek methods to interest qualified young Wisconsin students to enter the field of medicine, are Dr. T. H. McDonell, Waukesha, chairman; Dr. Russell F. Lewis, Jr., Marshfield; Dr. J. W. Rastetter, Milwaukee; and Dr. David Smith, Madison.

Pilot programs are now being planned for Waukesha, Marshfield, and a third community yet to be selected. The Department of Public Instruction and other state agencies will be asked to cooperate in the program.

Proposed Bill On Laboratory Animal Care

The pros and cons of a proposed U.S. Senate bill to regulate care of laboratory animals used in experiments were debated December 14 before an audience of about 150 people at the University of Wisconsin Medical School.

Mrs. Roger Stevens, New York, president of the Animal Welfare Institute, talked in support of the Cooper Bill, which didn't reach the action stage in the last Congressional session but will be introduced again this year. Dr. John Z. Bowers, dean of the medical school, debated against the proposed bill.

"Great progress has been made in recent years," said Doctor Bowers. "While there is still more to be done, the American tradition of getting things done is based on voluntary methods."

Many questions asked of Mrs. Stevens were based on the fear that the bill would inhibit research and would be a control which represented a potential dictation by the Federal government on what research should be done.

The two debaters agreed that more money was needed to care for animals used in scientific research. The problem was how to get it. Mrs. Stevens saw the answer in Federal controls while Doctor Bowers called for voluntary improvement spurred by Federal funds.

DOCTOR SIMENSTAD ON FAA ADVISORY PANEL

Dr. L. O. Simenstad, Osceola, is one of nine physicians appointed to the newly created Medical Advisory Panel of the Federal Aviation Agency.

The panel will review cases in which civil airmen desire exemption from medical standards.

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Prevention and Treatment of Postpartum Hemorrhage

By HERBERT F. SANDMIRE, M. D. and STEPHEN D. AUSTIN, M. D.
Green Bay, Wisconsin

POSTPARTUM hemorrhage continues to take its toll of lives in spite of the increased availability of blood banks, elimination of home deliveries, and the increased number of specially trained personnel in obstetrics and gynecology. Maternal mortality committees have been formed, locally and on a statewide basis, to determine the reason for this continued loss and to make constructive recommendations directed toward reducing the hazards of pregnancy.

Hemorrhage, accounting for approximately one-third of all maternal deaths, is about equally divided between postpartum hemorrhage and other types of hemorrhagic complications of pregnancy (placenta previa, abruptio, ectopic pregnancy, and abortion).[1,2] This presentation deals with the maternal losses resulting from postpartum hemorrhage with emphasis on preventive and therapeutic measures.

Maternal deaths are classified as preventable or nonpreventable, and the preventable deaths are further subdivided according to whether the physician, patient, or hospital is responsible. In reviewing reports of nine separate maternal mortality committees. Dalziel[1] found that 29 to 91% of all maternal deaths were classified as preventable and that the attending physician was responsible for 36 to 81% of the preventable maternal deaths. These figures are cited to point out the need for continued vigilance directed toward reducing maternal losses to an absolute minimum. Admission that a problem exists is an absolute prerequisite to its solution. Actually, a maternal death in any one physician's practice is rare and tends to breed complacency; hence, some lives are needlessly lost. Furthermore, some hemorrhagic maternal deaths are erroneously attributed to "coronary," neurogenic shock, embolism, or cardiac failure.[3]

Some physicians are critical of the work carried out by maternal mortality study groups and look upon them as an investigative body rather than an educational committee. This false impression can be corrected if we all adopt the sentiments of Dr. K. T. MacFarlane[4] when he states, "To err is a human propensity common to mankind and the cool realization of personal mistakes with their implications produces a lasting humility and breadth of character. By studying the mistakes of others we should also receive great benefit but hardly to the same degree as in the contemplation of our own."

Presented at the annual meeting of the Sixth District of the American College of Obstetricians and Gynecologists, Chicago, Illinois, November 11, 1960.

We do not believe we can over-emphasize the fact that hemorrhagic maternal deaths are preventable since failure of acceptance of this precludes the application of preventive measures.

"Postpartum hemorrhage is defined as bleeding from the birth canal in excess of 500 cc. during the first 24 hours after birth."[5] Hemorrhages subsequent to the first 24 hours will be discussed separately and will be referred to as late hemorrhages. The causes, including predisposing factors and preventive measures, will be discussed followed by the presentation of a management scheme for the patient with postpartum hemorrhage.

Causes, Predisposing Factors, and Preventive Measures in Postpartum Hemorrhage

A. Uterine atony. In uterine atony, which is responsible for 80 to 90% of all cases of postpartum hemorrhage, the myometrium contracts poorly and bleeding from the placental site occurs. Predisposing factors include multiparity, prolonged labor, multiple pregnancy, hydramnios, large baby, deep general anesthesia, previous postpartum hemorrhage, and placenta previa. In placenta previa the placental bed is located in the poorly contracting portion of the uterus and bleeding from the venous sinuses may occur.

The most important preventive measure is the administration of dilute intravenous oxytocin (Pitocin), for a few hours following delivery, to all patients having the predisposing factors listed above. The incidence of uterine atony can also be reduced by avoiding the injudicious use of deep general anesthesia and more energetic treatment directed toward the prevention of prolonged labor.

Inversion of the uterus, a rare cause of postpartum hemorrhage and shock, can usually be attributed to vigorous attempts at placental expression before separation has occurred or forceful fundal pressure on a poorly contracted uterus. Correct placental expression depends on downward pressure on the firmly contracted fundus until the separated placenta occupies the lower uterine segment and upper vagina followed by placing the hand just above the symphysis and exerting pressure in the upward direction, thus pushing the uterus away from the placenta. Treatment of uterine inversion consists of prompt manual replacement and transfusions, as needed, for correction of blood loss and treatment of shock.

B. Lacerations of the genital tract. Lacerations are usually associated with operative deliveries, traumatic intrauterine manipulations, obstructed labor, or oxytocin stimulation. The lacerations may involve the uterus, cervix, vagina, or perineum. Vaginal hematomas result from tears in the subvaginal tissue in the region of the ischial spine. The ordinary episiotomy may, occasionally, be responsible for considerable blood loss.

Placenta previa is a predisposing factor in cervical lacerations because of the friability of the placental site.

Uterine rupture may occur spontaneously in obstructed labor or result from traumatic intrauterine manipulations (podalic version and extraction of head and transverse presentations and the breaking up of an impacted frank breech presentation). These traumatic maneuvers, being associated with a 20 to 50% fetal mortality rate and adding considerable risk to the mother, have no place in modern obstetrical practice and should be replaced by Cesarean section. The only exception to the above statement is where one is dealing with the second twin in a transverse presentation. A podalic version and extraction may be performed here but only if done immediately following delivery of the first twin, since the uterus will soon contract down around the second baby making version hazardous. We have personal knowledge of a uterine rupture resulting from podalic version of a second twin performed after some elapse of time following precipitate delivery of the first twin. Uterine rupture is associated with a 50% maternal mortality rate primarily because of delay in diagnosis.

Cervical tears may result from forceps operations performed before cervical dilation is complete. Vaginal tears and extension of the episiotomy are common sequelae of forceps rotation operations. In the interest of both mother and baby the truly difficult mid forceps operation should be abandoned in favor of Cesarean section.

In summary, the prevention of serious obstetrical lacerations rests with the avoidance of outdated traumatic obstetrical maneuvers. Emphasis should also be placed on complete systematic examination of the entire birth canal following all obstetrical operative procedures greater in magnitude than the outlet forceps operation.

C. *Retained placental fragments.* Retention of placental fragments is the third most common cause of postpartum hemorrhage. Routine inspection of the placenta and fetal membranes should alert one to the possibility of retained fragments and/or accessory placental lobes. When there is a question of retention of a fragment, intrauterine examination should be done without hesitation.

D. *Clotting defects.* The most common coagulation defect associated with postpartum hemorrhage is afibrinogenemia. Predisposing factors are abruptio placentae, prolonged retention of a dead fetus (over 5 weeks), and amniotic fluid infusion.

Scheme of Management of the Patient With Postpartum Hemorrhage

Emergency situations are most properly and intelligently managed if a preconceived plan is formulated prior to the existence of the emergency. Postpartum hemorrhage is an emergency and the life of the patient depends on vigorous and proper treatment. The following management scheme has worked well for the authors; and, if followed, oversights are not likely to occur. The maneuvers outlined below should be carried out as rapidly as possible, some of them simultaneously.

1. If the placenta is still in the uterus at the time of the occurrence of the hemorrhage, it should be manually removed at once. Immediately following delivery manual removal of the placenta can be performed without anesthesia.
2. The uterus is then lifted out of the pelvis and moderate bimanual uterine massage is performed to keep the uterus in a contracted state. Lifting the uterus out of the pelvis lowers the pressure in the uterine veins, thus decreasing the bleeding at the placental site.
3. If the hemorrhage occurs after the patient has been taken to the ward or recovery room, she must be returned to the delivery room for examination. Insertion of a vaginal pack prior to a complete systematic examination of the genital tract is a grave error and reflects lack of understanding of the problem on the part of the responsible physician.
4. Extra help is summoned to allow for a minimum of one assistant, one scrub nurse, one circulating nurse, and one anesthetist.
5. Blood is drawn through an 18-gauge needle for cross match and the clot observation test. The needle is left in place and 5% glucose in water is started, using transfusion tubing with a blood pump attached. When the blood is available, it is given rapidly until the estimated loss is replaced. Plasma expanders and vasopressors should not be used except as a temporary measure while blood is procured. Blood should be procurable within an hour in all modern hospitals giving maternity care. If hypofibrinogenemia exists, as reflected by delayed clotting or formation of an unstable clot which disintegrates within one hour, 2 to 6 gm. of fibrinogen are given as needed for continued bleeding.
6. The patient is given a general anesthetic and the uterine cavity explored to detect retained placental tissue and uterine lacerations both complete and incomplete.

   If a placental fragment is found, it is removed. If a laceration of the uterus is found, laparotomy is performed and the appropriate treatment, usually total abdominal hysterectomy, is carried out. After completion of the manual exploration of the uterus one ampoule of oxytocin is added to the intravenous fluid or blood.

   Right angle retractors are inserted into the vagina and the cervix inspected by grasping it with ring forceps and "walking them" around the circumference. Cervical lacerations thus discovered are repaired with interrupted 00 chromic catgut suture.

   The patient is now placed in moderate Trendelenburg position, the uterus held up out of the pelvis by the assistant placing one hand just above the symphysis, and right angle retractors are placed to expose the entire vagina for quick inspection. Any lacerations seen are repaired.
7. Retained placental fragments, lacerations, and clotting defects have now been treated or excluded, and our attention can be directed toward the continued treatment of uterine atony Moderate uterine massage is continued

as is the administration of intravenous fluids with oxytocin. Uterine packing is not done at this time.

8. The patient is now observed for further bleeding; and if it occurs, she must be re-examined as above, preferably by another examiner. A uterine pack may be inserted at this time, being careful not to over distend the uterus, thus opening the venous sinuses. If bleeding through the pack occurs, total abdominal hysterectomy is mandatory.

Late Postpartum Hemorrhage

Hemorrhage subsequent to the first 24 hours following delivery is classified as late hemorrhage. Although it may occur as late as 8 weeks following delivery, the majority occur in the second postpartum week. In a recent report by Paalman and McElin[6] dealing with 450 cases of postpartum hemorrhage, 369 were immediate and 81 delayed. The sudden appearance of profuse bleeding following discharge from the hospital is disconcerting to the patient, and the attending physician is often at a loss to satisfactorily explain the course of events. Although the occurrence of late hemorrhage is embarrassing to the physician, it is not prima-facie evidence of poor obstetrical technique. Anyone in obstetrical practice will occasionally find it necessary to re-admit a patient for treatment of late hemorrhage.

The etiological conditions responsible for late puerperal hemorrhage are noninvolution of the placental site and retained secundines, each accounting for approximately one half of the cases.[6]

The treatment consists of replacement of the blood loss and systematic curettage of the endometrial cavity. Uterine packing and hysterectomy are unnecessary.

Summary

Common obstetrical errors contributing to postpartum hemorrhage and hemorrhagic maternal deaths are: (1) failure to recognize blood loss as being responsible for the patient's condition, resulting in delay in treatment;[3] (2) performance of outdated traumatic obstetrical maneuvers (podalic version and extraction, breech extraction, and difficult mid forceps); (3) failure to systematically examine the entire genital tract in all bleeding patients and following all obstetrical operations greater in magnitude than the outlet forceps operation; (4) over-dependence on vasopressor agents and blood substitutes;[3] (5) failure to obtain the services of a qualified consultant for all complications and operative procedures;[2,3] (6) injudicious use of oxytocin (Pitocin) for induction and acceleration of labor with resultant uterine rupture.[3] Oxytocin should be used only on definite indication and with the attending physician in constant attendance. Intramuscular administration must be replaced by controlled intravenous administration of a dilute solution (0.5 cc. per 1,000 cc. of 5% dextrose in water).

Deaths from postpartum hemorrhage are preventable. Prevention rests with prompt correction of the cause together with immediate replacement of the estimated blood loss. The causes, predisposing factors and preventive measures are outlined. A management scheme is presented to aid in the elimination of oversights in the diagnosis and treatment of postpartum hemorrhage.

430 S. Webster Avenue.

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SMS ANNUAL MEETING • MAY 2–3–4, 1961

May 2: Internal Medicine, Obstetrics and Gynecology, Pathology, Psychiatry, "Fireside Conferences" (Chest Physicians, Tuesday evening).

May 3: General Practice, Internal Medicine, Gastroenterology, Orthopedic Surgery, Pediatrics.

May 4: Anesthesiology, Ophthalmology and Otolaryngology, Radiology, Surgery.

SEE PRELIMINARY PROGRAM ON PAGES 165–169 THIS ISSUE

Husband of the Gynecologic Patient

By F. JACKSON STODDARD, M. D.
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CONTRARY to what the title suggests, this is not a 1960 revision of the Kinsey report on the American male. Rather, the idea came from the observation of a woman in labor, reading a magazine and smoking a cigarette, while her dutiful husband rubbed her back. In days gone by the expectant father was behind the plow or working in the blacksmith shop, while now he is expected to play the role of back-rubber. This he usually does without question.

The management of women patients is influenced considerably by the husband's attitude. The degree of success we may attain is in no small measure related to our understanding of the type of husband with whom we are dealing. The place of the American male has subtly changed in this century; the change has been especially rapid in the past decade or two.

Without passing judgment on this change, it might be well to classify husbands as they appear to the gynecologist, or rather, to a gynecologist. Modern medicine dictates that we classify. (Table 1) To my knowledge husbands have not previously been classified by gynecologists. Psychiatrists and family social workers do, but we do not. By trying to understand the different types of husbands, we sometimes find the reason some women respond better to our treatment than others. It is not an original observation that no matter how different the background and makeup of husbands and wives, if they are sexually compatible, the marriage is usually a success. Some of the husbands in the classifications will appear to be impossible individuals. They do exist, and many of the reasons for their being what they are is due to their wives. Their wives may like them the way they are or subtly fashion them to their own liking. If wives recognize their husbands in any of the categories, let them remember that the responsibility for the traits, good or bad, may be to a great extent their own.

TABLE 1—*Modern Husbands*

1. Normally Devoted	6. Mother's Boy
2. Organization Man No. 1	7. Competitor
3. Organization Man No. 2	8. Traveling Man
4. Egocentric	9. Troubled
5. Pseudoscientist	10. Suspicious

It might be appropriate to comment on each of the types of husbands in the classification.

1. Normally Devoted. This man is interested in his wife's problems and accepts explanations of her illness. He has confidence and trust in the physician's judgment. It is evident that he knows people have confidence in him and his judgment regardless of his occupation, or station in life, whether he be carpenter or college president. We all classify ourselves in this group.

2. Organization Man No. 1. His wife's illness is an irritant in his busy existence. He wants action, prompt scheduling of surgery to fit his business obligations, the biggest room in the hospital, and three shifts of special nurses. If you sense any reluctance to accept your plan of management of his wife's case, prompt suggestion that another opinion might be indicated may aid in establishing you as the "chairman-of-the-board" of this situation. For relatively minor problems which time may take care of, he urges definite action, such as hysterectomy instead of curtailing activity at period time and attempts at conservative therapy. Anything which may disrupt his plans (business or vacation) is not acceptable. Anticipation of questions which his thoroughly organized mind will ask may be the key to handling him properly.

3. Organization Man No. 2. This fellow is so anxious to climb the ladder in the corporation that anything, including his wife's illness which might interfere, is unacceptable. He is a small edition of Organization Man No. 1. Not having become completely successful, he is concerned that her illness may

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From the Department of Obstetrics and Gynecology, Marquette University School of Medicine, Milwaukee.

threaten his future success. He is anxious, but more about how her illness will affect him than about his wife's welfare. He forces her to "keep up with the Joneses," thereby producing anxiety states.

4. Egocentric. When you try to discuss his wife's problem, he skillfully shifts the conversation to himself, frequently to his own illness. He has to be jarred from this at times by slight exaggeration of his wife's illness. He is adolescent in his reactions. His wife is responsible for his success, but he does not seem to realize it. He can hardly wait to leave the hospital with his beret and sports car and get to the country club. (One wife with no apparent organic problem came in for unusually frequent checkups because she said her husband seemed to think he was the only one who ever got sick. She thought she deserved to share the family's medical expense.)

5. Pseudoscientist. This fellow is a product of the lay press and higher education for the many. He is usually cooperative but likes detailed explanations and especially pictures. Carefully chosen words by the physician regarding the vagaries of menstrual function help avoid misunderstanding. If he becomes too difficult, suggest consultation before he requests it. His wife usually humors him in his hobby of pseudoscience.

6. Mother's Boy. He has been covered adequately by Edward A. Strecker in, "Their Mother's Sons."[1] This husband marries someone who will mother him, and he is terrified by his wife's illness. He anticipates the worst and is a worrier. She waits too long to have surgery and begs to be discharged early postoperatively. She does not always do well because she is afraid her husband can not get along at home without her—and he often cannot. The physician may recognize this combination early in marriage. If the wife feigns illness or carefully avoids household duties and chores which generally belong to the husband, sometimes he grows up. She may like her role of mother substitute and her husband certainly does. The physician, by recognizing the combination, can better understand his patient's reactions to her gynecologic problem.

7. The Competitor. This fellow competes with his wife throughout their marriage. Often she brings in as much income and does all the housework or supervises it. She is stalwart, aggressive, and suppresses her femininity. He is capable and has many of her same traits. They both seem to thrive on competition at home and in business. If this husband seems less than attentive during his wife's illness, it is perhaps understandable. Now is his chance to get ahead of her. Being the same type of people they understand each other. She does not feel neglected.

8. Traveling Man. He is an overnight guest or weekend visitor in his own home. Having been mother and father all week, mother wants weekend entertainment and father wants to rest. Friction occurs on this score, and mother sees a physician because of so-called nervous exhaustion and frustration. This fellow accounts for the Saturday afternoon and evening phone calls to the doctor. He can stand just about 24 hours of nagging before crying for medical help. At times changing the routine and discussing the genesis of this problem with both husband and wife is more helpful than amphetamines, tranquilizers, or hormones. It is time that those who concern themselves with environmental medicine take cognizance of the often disturbed and unhappy wife of the traveling man. This fellow is on the increase and stays away longer with overseas traveling, thereby compounding the problems.

9. Troubled. A wife who is married to a man who has troubles—financial, family, friends—all the time, often has difficulty showing enthusiasm about a good surgical or medical result. His inability to think of anything but his troubles generally makes him of no help in his wife's problems. He may be temperamentally unsuited to his job, and his family suffers because of his insecurity.

10. Suspicious. One woman physician told me recently that 5% of her patients came to her because their husbands did not want any other man looking at them. If a husband is suspicious, having a nurse present during the examination helps reassure him. Here again, frank explanation and offer of consultation is reassuring. If this type becomes too obnoxious, the suggestion that his wife see another physician is best.

The management of specific gynecologic conditions may be influenced by the relationship and attitudes of husbands and wives as illustrated by the following brief case histories, many of which you will recognize as having seen in practice.

Menometrorrhagia

A 35-year-old woman with a normal blood count, both before and after periods, complained of almost continuous vaginal bleeding, heaviest at period time. Curettage revealed normal secretory endometrium. After failure to control the bleeding with medical treatment, she finally admitted that she was only spotting a few days before and after periods. She realized that she was exaggerating the amount and duration of bleeding as an excuse for avoiding intercourse.

A 48-year-old wife of a busy executive had such profuse and irregular menstrual flow that she felt insecure about planning dinner parties and going on business trips with her husband. She was in good general condition, but the bleeding failed to respond consistently to medical management after curettage. Both husband and wife urged hysterectomy because of the inconvenience. Twenty years ago and before, when surgical therapy was less safe than today, such a patient would have settled for bed rest, hematinics, and time; and in many instances the patient would ultimately have been cured by the menopause. Conversely, if a friend or relative of either husband or wife had complications following surgery, they might insist on following a conservative course.

The busy professional or club woman, who finds even normal menstruation interfering with her carefully planned existence, is frequently unwilling to tolerate menstrual excesses or irregularities. She and her husband may try to force the physician into action rather than have her accept the temporary inconvenience of womanhood.

What may be only a bother to one patient, may be totally unacceptable to another. The husband's attitude may make the difference.

Infertility

A few years ago a husband usually sent his wife to the physician to find out why they were not having babies, now the wife frequently comes in for her first visit armed with a semen analysis report. Probably male impotence has always been present. It seems to be increasing. The eager, hopeful, highly educated bride who pinpoints ovulation by a variety of methods, and tries to regulate her marriage bed by a graph, may reduce a sensitive husband to impotence. This wife may be recognized by the neat list of questions she brings to the office and by the precision with which she takes notes on each of the physician's remarks.

With approximately one-third of the young married female population keeping house and working outside the home full-time as well, it is not surprising that fatigue results. When she is tired her husband is not, and vice versa. This discrepency, if unrecognized, may be a cause of infertility as well as marital incompatibility.

Sometimes couples appear indifferent, to say the least, in pursuing infertility studies. One patient of a colleague of mine was always escorted to the office by her husband. All studies were consistently negative. One day the physician embarrassed the patient when he found a contraceptive diaphragm which she had forgotten to remove. She submitted to infertility studies merely to keep her husband happy, not because she wanted a child. Contrariwise, some husbands are very happy to have wives studied completely, but any suggestion that there might be a male factor is rejected.

Premenstrual Tension

The patient in her thirties is often sent to the office by her husband and children because they cannot get along with her. Careful questioning reveals that it is essentially a premenstrual phenomenon. Treatment with a diuretic and reassurance that she is not mentally ill generally helps. Consultation with her husband and explanation that at this time of the month more women have auto accidents, more arguments occur, and, incidentally, more husbands are murdered by their wives, may be helpful. Both husband and wife should watch the calendar a little more accurately, and at all costs avoid controversial issues during the week before periods.

Amenorrhea

This is sometimes found to be a symptom of marital stress after a reasonable medical and gynecologic study has been made to rule out organic causes. Sometimes a frank discussion of personal and marital problems with the patient and a cooperative husband corrects this type of amenorrhea.

Relaxed Pelvic Floor

A 35-year-old multipara complained of bearing down pelvic discomfort. Minimal cystocele and rectocele were the only demon-

strable pelvic pathology. Shortly before the anticipated date of surgery, divorce proceedings were instituted and surgery was cancelled. This may have been a case of pelvic congestion syndrome, associated with tension incident to a troubled marriage. While Howard Taylor, Jr.'s pelvic congestion syndrome is difficult to prove, it should certainly be considered before undertaking surgical correction of minimal deviations from normal in patients with marital difficulties.[2] From earliest times, the female pelvis has been accused as the cause of myriads of symptoms befalling womankind. Minimal relaxation and displacements are usually asymptomatic, and correction will rarely lead to cure of the symptoms. A frank discussion with the husband about the futility of surgery in such cases may save the uncertain patient from endless pursuit of relief.

Hysterectomy

This connotes different things to different people. For example, one college graduate husband was very reluctant to consent to surgery when his 38-year-old wife was suffering from a large, painful, degenerated fibroid. The reason was that he thought hysterectomy meant the end of sexual activity for her. She underwent much unnecessary discomfort before he was made to realize that such would not be the case.

On the other hand, this type of situation is more frequently encountered. A patient is found to have an atypical Papanicolau smear on routine examination. This is the only significant finding. Some husbands are so frightened of cancer that it may be difficult to persuade them to let their wives have appropriate diagnostic studies. Pressure to perform a hysterectomy here may be motivated by unnecessary apprehension. In this case the offer of consultation may be the best protection for the physician and aid in convincing a panicky husband or wife of the wisdom of diagnostic conization before considering hysterectomy.

Role of the Gynecologist

There are a number of ways which we, as gynecologists, can help in our patients' family relationships:

1. Emphasize to the patient that while she may be as well educated as her husband, and able to earn (if not actually earning it) nearly as much, this new feminine role may undermine his confidence in himself. His being away from home much of the time makes him a less effective father to his children, and his wife plays the role of both mother and father. She must make decisions that she would prefer him to make. It is up to her in this era to help her husband keep his faith in himself as a husband and father. If she fails to recognize these changes, she may convert him from a devoted husband to a combination of the less desirable types.

2. Evaluating which type of husband or which combination of types he happens to be may be important in explaining the nature of his wife's illness. Anticipating questions the husband may ask may obviate medicolegal entanglements and result in happier patients.

The suggestion that the patient have her husband either phone or make an appointment to discuss the diagnosis and reasons for treatment often avoids misunderstandings.

3. Particularly in young patients requiring major surgical procedures, consultation should be recommended—with a consultant of the patient's choice. This frank offer is usually refused, but appreciated by the patient and her husband.

The question may be asked, "Where does a busy physician find time to do all this?" The answer is that a short, frank discussion with both the patient and her husband early in the case usually saves time later.

4. A standard explanation to the husband of his wife's condition is not sufficient in many instances. At times, slight over-emphasis of the seriousness of the condition when talking to a casual husband may be both necessary and beneficial to her recovery. On the other hand, if the apprehensive husband is not made aware of the seriousness of his wife's condition gradually, his uneasiness may be transferred to his wife.

5. It is well established that nearly all gynecologic conditions have their emotional components. If the husband, through our efforts, is led to understand some of these components, it may spell the difference between success and failure in our treatment.

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Tonography — An Advance in the Diagnosis, Prognosis and Treatment of Glaucoma

By LAWRENCE L. GARNER, M.D., F.A.C.S.

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TONOGRAPHY is a method of investigating the flow of aqueous humor from the eye by recording the changes in ocular pressure that occur when an electronic tonometer, hooked up with an amplifier-recorder, is placed upon the anesthetized cornea for four minutes. This type of investigation was made possible in 1950 when Grant,[1] published his first report of such an apparatus and at the same time developed tables that permitted rapid estimates of the coefficient of aqueous outflow which he called "C." The C, therefore, was a measure of the ease with which fluid could be expressed from the eye or a measure of the resistance to this outflow. Since the basic disorder in most glaucomas is an obstruction to the outflow of aqueous humor from the eye, and since an impaired outflow is one of the earliest findings, even before an elevation of pressure, we now have in tonography a simple and precise means of estimating the ease with which fluid can leave the eye. This does not imply that tonography will supplant our other known and improved methods of glaucoma evaluation, but it can be utilized as an adjunct in the hands of the ophthalmologist. The purpose of this presentation is to demonstrate the clinical application of tonography in the diagnosis, prognosis and treatment of the patient with glaucoma.

Values

The theories and mathematical formulas for calculating the facility of aqueous outflow will not be repeated, for these were well documented by Grant[1] and others. The original calculations were formidable enough to discourage the most rugged enthusiast, but with today's simplified tables one can inspect the tracing and tell at a glance the values for the intraocular pressure (Po) and the facility of outflow (C). The latter is expressed in terms of cubic millimeters per minute per millimeter of mercury pressure and normally ranges from 0.20 to 0.35 with a small percentage of normal tracings showing a C slightly below 0.20. Most of the latter can be separated from the normal by combining a water provocative test with the tonography. Open-angle glaucoma, as a rule, presents a C value that is consistently below 0.18, so that any reading below 0.20 in our Center is considered suspect until proved otherwise. Because of a percentage of overlap one can make the following statement: if the C is between 0.15 and 0.19, be very suspicious of glaucoma, since this is the doubtful range. If the C is below 0.15, there is real concern because it is rare to find an untreated glaucoma with a C greater than 0.15 except when the tracing is made at such a time when the diurnal dip is low. This is seen in middle-aged persons who are in early stages of involvement and is not readily explained. Therefore, it is advisable to take readings at different times of the day to rule out this factor which could account for a false low reading.

The Po/C ratio is a useful fraction described by Becker,[2] and although an empirical value, affords an accurate estimate of the clinical status of the patient. It is particularly appreciated in the patient who presents a normal pressure reading or near normal with or without therapy, but at the same time shows an impaired C value. A Po/C value greater than 100 is strongly suggestive of glaucoma, while under 100 would be considered normal. In the patient under treatment these values are a guide for indicating the adequacy or inadequacy of the control; and for the equivocal case of early glaucoma, the addition of a water provocative test will result in a 97% accuracy of the diagnosis.

The rate of flow, or F value, will not be detailed but can be easily computed from the

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From the Glaucoma Consultation & Referral Center, Marquette University School of Medicine.

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formula $F = C\ (Po–Pv)$, the Pv being a standard value of 10 for the episcleral venous pressure.

Procedure

The electronic tonometer (Mueller) is the only one available at this time and it is essential that this be hooked up with a recording device of which there are several (Sanborn, Esterline–Angus, Brown, Leeds–Northrup). The electronic tonometer has two distinct advantages over the regular Schiötz instrument, viz., easier and greater accuracy of the readings and easier maintenance of position on the cornea. While it is possible to employ the electronic tonometer alone and take readings at the onset and four minutes later, one will never know if this is a good or bad tonogram unless one is able to see what has occurred during the four-minute interval. Some have attempted to take readings every 15 to 30 seconds; and while this is an improvement, it does not equal the advantage of a continuous four-minute tracing which will be demonstrated later.

Two drops of benoxinate hydrochloride (Dorsacaine) 0.4% are instilled in each eye while the patient is made recumbent and comfortable in a modern-type barber chair. The latter is useful because it permits the patient to sit and relax during conversation, following which the chair is slowly adjusted to a degree of recumbency compatible with the comfort of the patient. The patient is asked to fixate an overhead small red light or varied colored crosses (Bandaids) on the ceiling to position the eyes, following which the tonometer is poised over the eye but not placed onto the eye for about 30 seconds (to allow muscular relaxation). The lids are retracted to avoid pressure on the globe and thus create false elevated readings. This is pertinent with female technicians who have long fingernails and prefer not to trim them, so instead must master a technique that is essentially good but has a greater tendency to apply pressure to the globe unless scrupulously observed. By poising the tonometer over the eye and not permitting the patient to know when contact is made, relaxation of muscles can be felt by the tonometrist thereby avoiding false readings. Once contact is made, the position must be maintained on the vertex of the cornea, and steadiness of the tonometrist can be assured by resting the hand on the forehead or the elbow on a portion of the chair. In the case of the one-eyed, or patients with strabismus, the patient can be trained to gaze into the center of the round shadow that can be seen when the tonometer descends and thereby avoid a chaotic type of tracing.

For satisfactory tracings, several fundamentals must be recognized. Tonography is a simple and fairly precise and practical means of determining outflow values, but like some other laboratory procedures, i.e., the basal metabolic rate and the electrocardiogram, it has potential sources of error and is also subject to certain technical problems. The use of trained personnel, calibrated equipment and the observance of certain fundamentals should result in reliable and repeatable tracings. Ideal surroundings should include a sound-proofed, air-conditioned room using colored lights in place of a phone signal and be free from interruptions. A relaxed patient with loose collar and no dependency of the head will avoid false elevated readings of the Po and C. A coughing patient, an uncomfortable patient or an apprehensive patient should not be examined. Care of the tonometer should include the use of lint-free paper to avoid any impairment or friction; and to avoid consensual increase in the C that may occur, the second eye should not be examined until five minutes have elapsed after examination of the first eye.

Clinical Application

Diagnosis: Figure 1 shows a normal tonogram. Note the downward slope of the tracing, which is lost in Figure 2, that represents a classical glaucoma tracing with its flattened curve, its elevated Po, reduced C and Po/C ratio over 100. The reduction of the outflow facility here readily can account for the elevation of the intraocular pressure.

Since the advent of tonography, we know that a patient may have a normal Po, but at the same time present an impaired C value. This is particularly true in the early stages of glaucoma in which some eyes can adjust to the obstruction in outflow by a decrease of inflow secretion of the aqueous humor. In Figure 3 if the tonometer alone were used, the diagnosis would be missed or at best be considered equivocal, while with the tonogram we now have a means of eliciting a positive sign long before manifest evidence of glaucoma which involves the nervehead. Given enough time this patient will eventually demonstrate other signs to corroborate

O.S. 5.5 WT. Po = 12 C = .32 Po/C = 37

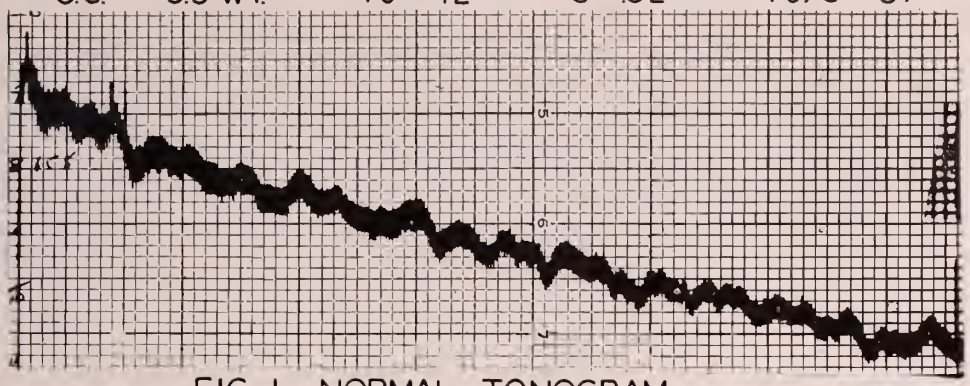

FIG. 1 NORMAL TONOGRAM.

O.S. 10 WT. Po = 34 C = .08 Po/C = 425

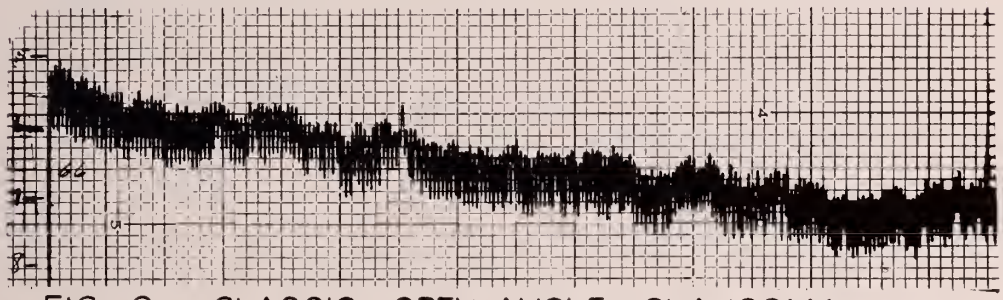

FIG. 2 CLASSIC OPEN-ANGLE GLAUCOMA UNTREATED

O.S. 5.5 WT. Po = 23 C = .09 Po/C = 255

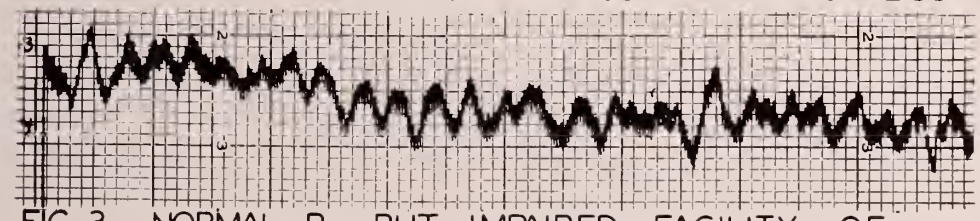

FIG. 3 NORMAL Po BUT IMPAIRED FACILITY OF OUTFLOW. NOTE NEXT SLIDE.

O.S. 10 WT. Po = 42 C = .02 Po/C = 2100

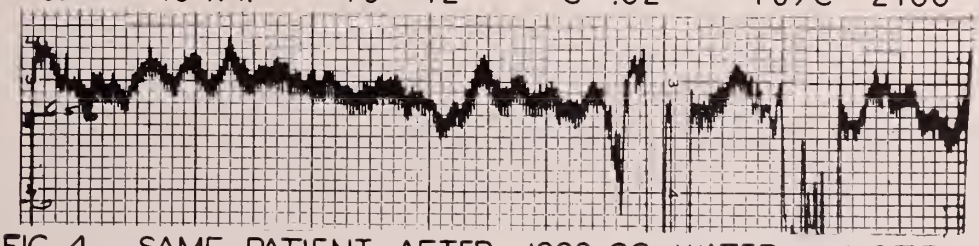

FIG. 4 SAME PATIENT AFTER 1000 CC WATER. NOTE ELECTRICAL IMPULSES UNKNOWN ETIOLOGY.

the diagnosis, but these are at the expense of visual function.

Does my patient have glaucoma? This is a common request noted on the referral blank accompanying the patient to our Center. Despite reluctance to utilize a single tracing for definite diagnosis, we feel that a tonogram that combines a normal intraocular pressure (Po) with an abnormal C suggests further investigation, because this patient may be on the threshold of serious trouble. Because of the many factors involved, repeat tracings are ordered at this Center routinely; and in the case just mentioned, Figure 3, a water provocation test is employed for the purpose of further embarrassing the outflow disorder. Figure 4 reveals the increase in Po value to 42 and the decrease in C to 0.02 after 1,000 cc. of water is ingested. The test here is now a positive one for the diagnosis of glaucoma. Unfortunately all early cases of glaucoma are not easily delineated; and we occasionally find, even after the water drinking test, equivocal results that show a minimal effect on either the C value or the tension in the eye, at times even showing a lower pressure reading than before the ingestion of water. These are the patients who present no clinical findings at this time other than an occasional borderline tension, but who present suspicious early signs of an impairment of the C. We now have a number of these who are being followed at three-to-six-month intervals for we have been alerted by this suspicious lowered C and have found two patients who have gone on to present a gradual increase in impairment of the outflow facility indicating that these patients warrant continued observation.

It is now well known that chronic glaucoma can occur in families, and it is in the adult members of this group that tonography offers the means of finding early evidence of an outflow impairment such that a Po/C value over 100 may be the first evidence of the tendency toward glaucoma.

Treatment

The use of miotics, such as pilocarpine, effect a lowering of the Po by improving the outflow of aqueous humor. Figure 5 is that of a patient on miotic therapy. The tonogram is not normal for the Po is 19, the C is 0.15, and the Po/C ratio is greater than 100. Note that although the Po is normal the outflow C is lower than normal. Figure 6 presents the same patient after more intensive therapy and an improved status is noted. In most instances we can demonstrate that miotics, filtering operations and in select cases 2% levo-epinephrine, lower the Po by improving the facility of the outflow. On the other hand the carbonic anhydrase inhibitors and 2% levo-epinephrine seem to lower the Po by suppression of aqueous secretion for the C value does not appear to be greatly affected.

When a positive diagnosis of glaucoma in a new patient is found, we inaugurate therapy at once and find that 1% pilocarpine given each evening at bedtime for seven days will usually allow for adaptation to the ciliary spasm. Pilocarpine is then increased to twice a day for seven days and the tonogram is repeated. In the patient with early glaucoma pilocarpine will improve the C and therefore can be used as a therapeutic test because in the normal patient the C will not change significantly.

In the patient whose eyes are made normotensive by either surgery or medication the observance of periodic tonograms may give the first indication of failure of therapy. The finding of a tendency to flattening of the tonogram curve, or a gradual decrease in the C value, should alert the physician to the possibility of an impending rise in the intraocular pressure, so that more intensive therapy can be instituted to normalize the outflow and therapy prevent loss of visual field. The point to remember is that the fall in C value always precedes the rise in Po. Therapy instituted at this point will convert a lowered C to a normal C and assure a better prognosis for the patient. Since the patient with a normal Po value and a lowered C has a greater likelihood of losing visual field than the patient with both Po and C normal, the tonogram now offers assistance not only for therapeutic but also for prognostic purposes. A falling Po/C value would tend to a better outlook than the patient under therapy whose Po/C value continues to remain well over 100.

Do not hesitate to push local therapy to a maximum in the patient with a falling C in the face of normal or equivocal Po values. If you do, the visual field loss may begin or progress by the time you start planning for surgical intervention. On the other hand, if the C is normal and the Po is up most of the time and yet there is no evidence of visual field loss, you may be sure that if you wait long enough the visual field loss will take

O.S. 7.5 WT. Po = 19 C = 15 Po /C = 121

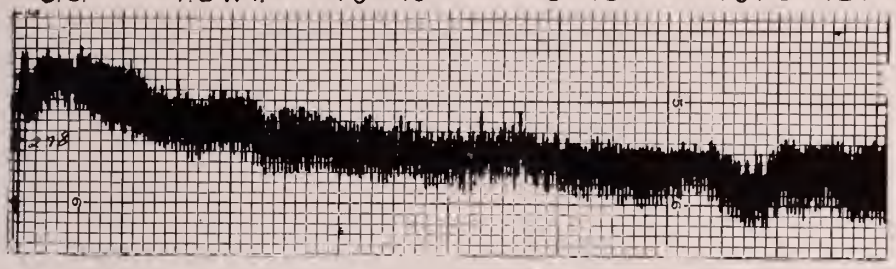

FIG. 5 PATIENT ON PILOCARPINE 4% Q.I.D. + LEVO-EPINEPHPRINE 2% H.S. SUGGESTS MORE INTENSIVE THERAPY ADVISABLE.

O.S. 5.5 WT. Po = 18 C = .21 Po /C = 89

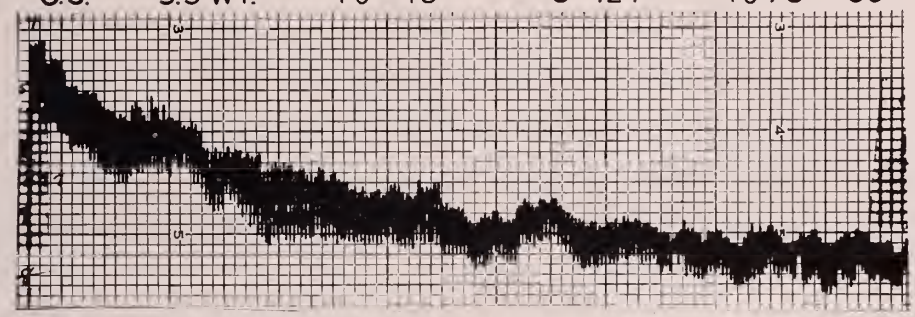

FIG. 6 NORMALIZATION OF Po & C ON COMBINED DEMECARIUM BROMIDE LEVO-EPINEPHRINE 2% PLUS ACETAZOLEAMIDE S-R

O.D. 5.5 WT. Po = 15 C = .18 Po /C = 83

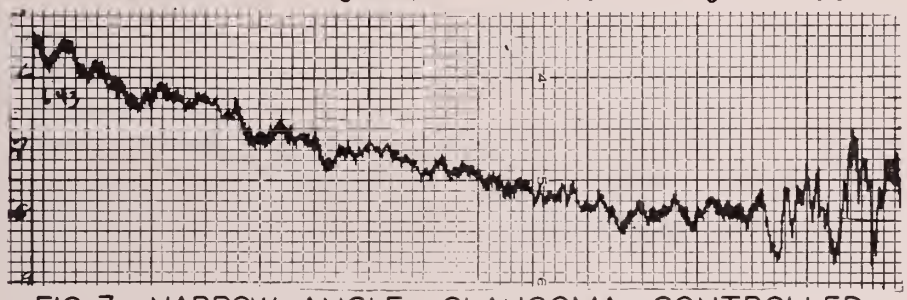

FIG. 7 NARROW-ANGLE GLAUCOMA CONTROLLED ON INTENSIVE THERAPY. NOTE C VALUE.

O.D. 5.5 WT. Po = 15 C = .34 Po /C = 43

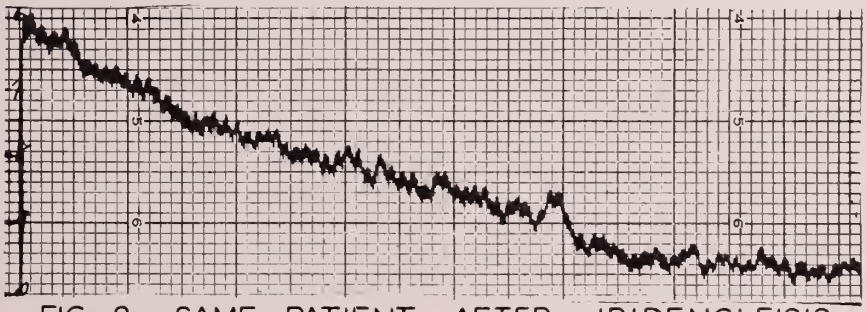

FIG. 8 SAME PATIENT AFTER IRIDENCLEISIS

place in some instances. One has to use clinical judgment and not plan to operate on the tonographic findings alone. Tonography must be used as an aid or adjunct to our other findings; and if surgery is contemplated it should be done while the field of vision is still good.

In the case of narrow-angle glaucoma which is normalized by medication or when it may be normal in between attacks, the tonogram is superior as a criterion for the type of surgery to be performed than any of our previous methods of evaluation. A normal C value tells us that a peripheral iridectomy would be successful, while an abnormal C would suggest a filtering procedure as the more propitious and with the greatest likelihood for success. Figure 7 shows tracings of a patient with narrow-angle glaucoma under intense therapy of miotic and carbonic anhydrase inhibitor whose Po is normal (15) but whose C is somewhat below. When the intensity of therapy is reduced, both values show signs of decrease in glaucoma control. This type of patient would benefit by a filtering procedure while an iridectomy would most likely prove futile. Figure 8 presents tracings of the same patient with marked improvement made possible by a filtering procedure. This patient no longer needs any local therapy but should have repeat tonograms at 90-day intervals and then farther apart to assure patency of the outflow channels.

Tonography has a very definite place in the secondary glaucoma conditions which can be well controlled with one of the carbonic anhydrase inhibitors, for as the C improves with clinical improvement of the basic disorder, the physician can clinically adjust his dosage and eventually stop all drug when the C has returned to normal. The blind method of continued medication can thereby be avoided by repeat tonograms on these patients.

A possible source of error that has not been mentioned is the scleral rigidity factor (E) which is pertinent only academically, for it occurs perhaps in possibly 2 to 4 out of 100 cases, but is in itself important because of the many factors still not understood. To avoid abnormally low or high readings that may occur, we now employ the applanation tonometer first, then perform tonography and use the nomogram for calculation of the E factor, correcting for it if present. Tonography in this manner is an aid in obtaining a correct diagnosis in the occasional case of abnormal scleral rigidity. For example, let us assume that the tonogram reveals a Po of 17 and a C value of 0.10 which could represent a glaucoma patient with a low scleral rigidity or the presence of a hyposecretion glaucoma. In either event, the use of the hand tonometer would have called this normal, but the presence of the abnormal C clearly indicates the need for further investigation. On the other hand let us assume that the tracing gave us a Po of 30 and a C of 0.38 which at a glance shows the presence of an elevated pressure in the face of a normal C value. Is this glaucoma or is it not glaucoma? Without the tonogram we would call this an abnormal pressure, but with the tonogram we now suspect either an abnormally elevated scleral rigidity or a hypersecretion type of glaucoma, both quite uncommon. Since a high E value produces higher Po and C values than actually exist, the tracing suggests investigation of the E factor and thereby lends accuracy to the diagnosis.

A common source of irritation is the matter of the tonogram itself, and unless scrupulous attention is paid to every detail from proper electrical installation to an understanding of the many factors that go into the making of a good tracing, one may find the creating of a tonographic laboratory an exasperating experience. Our first recording tonometer was prepared for us through the courtesy of Dr. Joseph Haas of the University of Illinois Eye and Ear Infirmary and employed an Esterline–Angus modified commercial recorder. The tracings left much to be desired. A Leeds–Northrup type of recorder was later added and Miss Genevieve Guilfoyle, R.N., was subsequently trained as a technician to perform these tests. As a result of these changes our results, while not free from problems, are far superior to those previously experienced.

Incidental Findings

During the course of operation of a tonographic center, one will occasionally find a most bizarre type of tracing as in Figure 9. This was found in a woman who was unaware of any cardiac irregularity. Note the findings after she was referred back to the referring physician for care, Figure 10. To the beginner or novice, the abnormal tracings that can and do occur are most trying, and mention of a few at this time can do

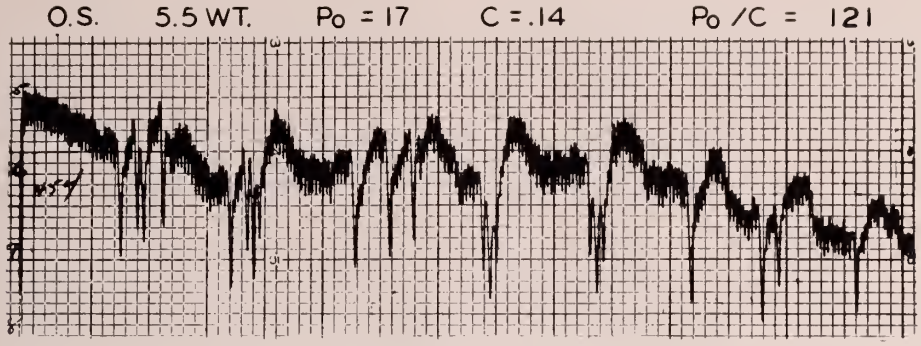

FIG. 9 CARDIAC ARRYTHMIA

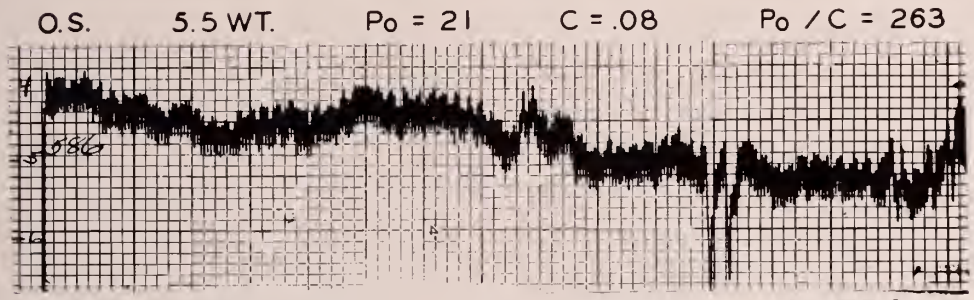

FIG. 10 SAME PATIENT AFTER MEDICAL CONTROL OF ARRYTHMIA

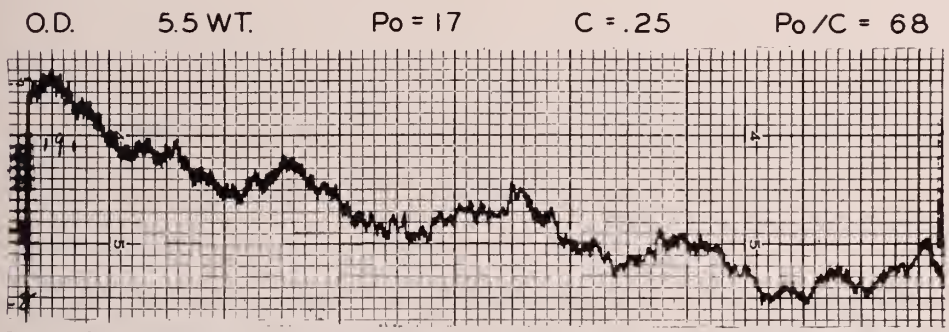

FIG. 11 OPEN-ANGLE GLAUCOMA CONTROLLED ON DEMECARIUM BROMIDE PLUS LEVO-EPINEPHRINE 2% A.M. & P.M. NOTE LARGE PULSE WAVE

much to dispel the fear and uncertainties that can arise. It is good practice to take the pulse of each patient before taking the tonogram because vascular effects have decided influences on the tracings. Vasodilitation from drugs or blushing can result in a transient rise in the pressure. Occasionally one notes a sharp rise initially followed by a sharp drop during the first minute. This is now attributed to blood pressure changes secondary to anticipation on the part of the patient, and/or ocular muscle spasm produced when the tonometer is seen descending onto the eye. Figure 11 shows another type of confusing curve which is not completely understood at this time but appears to be related to the pulse pressure. This is the type of patient in whom errors could readily be made in reading the tracing or using just the tonometer to measure the pressure. One could readily read the tonometer at the height or depth of a wave and never be aware of the error. This is a normal tracing for some patients and is easily read by drawing the best curve without using the high points of the waves. Other factors that affect the trac-

ings involve movement of the eyes, holding the breath, swallowing, sighing, straining, interruptions by outside noises, tenseness of the patient, discomfort from bathroom urgency, and multiple other factors still in the process of evaluation, all of which must be avoided or corrected if we are to produce serviceable tonograms.

Summary

Tonography will not replace any of our previous methods of examination, but it should be considered an adjunct in the medical armamentarium to aid in the diagnosis and treatment of glaucoma. It is not to be construed as a substitute for good clinical judgment, but when combined with other information, it offers considerable information in the evaluation and management of the patient. At times it may be solely responsible for the proper diagnosis of glaucoma because it offers the earliest possible type of information and is particularly useful in the critical decision as to the presence or absence of glaucoma, the adequacy or inadequacy of therapy, the prognosis as to possible future visual field loss, the decision as to type of surgery with greatest likelihood for success, and the possibility of impending medical or surgical failure. The presence of abnormal findings on the tonogram alerts the physician to the need for closer follow-up studies in order to avoid loss of visual function which in the end is the ultimate of all diagnostic and therapeutic measures.

Because of the potential sources of error, the complex and costly nature of the equipment along with the time consumed to attain adequate skill as well as good tonograms, it is unlikely that tonography will prove popular outside of special glaucoma centers or clinics.

ACKNOWLEDGMENT: We gratefully acknowledge the help of Miss Genevieve Guilfoyle, R.N., in the tonographic selections and studies.

545 North 15th Street (3).

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Treatment of Ascites by Indwelling Catheter

By LEON D. SOBUSH, M.D.

Monitowoc, Wisconsin

I wish to describe a simple method for the treatment of recurrent ascites which I found useful in two patients. One was a woman, age 45, with carcinoma of the body of the uterus who had to be tapped every two or three days. The second patient was a man, 45 years of age, with cirrhosis of the liver who had had repeated abdominal paracentesis.

The method is as follows:

Paracentesis is done in the usual manner in the left lower quadrant under sterile technique. The fluid is withdrawn slowly 50 to 75 cc. at a time with a short wait before removal of the next portion of fluid. When as much fluid has been withdrawn as possible, a sterile catheter is run through the trocar and the trocar is removed. A clamp is then placed on the catheter. The catheter is held in place by adhesive; the catheter and clamp are carefully covered. The patient is instructed to open the clamp and drain the fluid twice a day.

In the two patients, the catheter has remained in place for several weeks. They remove two to three liters of fluid per day themselves. There has been no evidence of infection.

Transition to Society

By EUGENE S. TURRELL, M.D.
Wauwatosa, Wisconsin

THERE are many aspects of the follow-up care of patients discharged from a psychiatric hospital and, in order to understand these, it will be necessary to concern ourselves first, with the causes of emotional illness, secondly, with the aims of hospital treatment, and thirdly, with the problem encountered in the return to society.

Generally, mental illness can be viewed as defensive reactions against psychologic stresses. These stresses include external psychologic stresses and internal stresses. An illustration of external stress may be the war neurosis in which men developed illnesses because of the traumatic nature of their experiences. Under some situations, even relatively healthy personalities may develop emotional symptoms because of the severity of the stresses. The internal stresses are generally the reactivation of infantile or childhood emotions and conflicts. These may be reactivated by particular present day experiences. An illustration might be the development of anxiety reactions when an employer or boss reminds the patient of a stern or punitive father. Here the illness may not be related to the realities of the stern boss but may be more a result of reactivated fears and anxieties suffered during childhood at the hands of a stern and punitive father.

Generally, the aims of hospitalization can be classified under three headings: (1) reintegration of the personality; (2) repression of emotions and conflicts, and (3) symptom relief or symptom reduction. Modern psychiatry is generally turning more and more efforts in the direction of reintegration of the personality. Here the psychotherapeutic approach is used both in an individual psychotherapeutic experience between the psychiatrist and the patient as well as in the psychotherapeutic aspects of the hospital milieu. Reintegration requires exploration of the sources of internalized conflicts, the awareness of certain fallacious responses, and the learning of adaptive patterns so that behavior will be integrated with the reality demands upon the person. In such integrative therapy, the patient gains ego support from the interest of the psychotherapist as well as interest of other hospital personnel.

Additionally, there may be emotional discharge through the process of catharsis in talking with the therapist about the external and internal conflicts and emotions. Additionally, decreased anxiety and guilt result from the therapist's tolerance and explanation of the feared emotions or conflicts. Experiential insight results from the new relationships established with the psychotherapist or other hospital personnel and this experiential insight can be utilized in the formation of relationships outside of the hospital. Additionally, intellectual insight may be gained so that the patient develops controls over his behavioral patterns and more successfully adapts these to the demands of reality. All of these processes are utilized in the reintegrative approach to therapy.

However, certain patients may lack sufficient ego structure and strength of character, or the internalized traumatic events may be so painful and traumatic that reintegration is impossible. Here, repressive therapy may be of value. These therapies, electroshock therapy and insulin therapy, are generally termed the somatic treatments. Generally, the patient is aided in the repression of intense emotional experiences and conflicts so that, though they remain in the unconscious, they do not influence the patient's behavior to such a great extent as during the illness.

An example here is the middle-aged patient, Mrs. X., who came to the hospital with many physical complaints and a mild depression. As we explored her past experiences, it became evident that she was unable to tolerate the re-experiencing of the death of her parents in an automobile accident. Any ap-

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proach to this subject led to an increase in the depression. Finally, she became so depressed that it was our opinion that she should have electroshock therapy. When this opinion was expressed, she responded, "Oh, Doctor, I wish you had not even mentioned the possibility of this." She was asked if she would prefer to have been carried to the treatment room and given the treatments without asking her to make the decision, and she responded, "Oh, yes, Doctor. I would have much preferred it that way." This seemed to indicate an almost complete lack of alliance on the part of her ego with our attempts to relieve her illness. It was, also, our opinion that this indicated the lack of ego available to reintegrate the painful experiences and ambivalent feelings concerning the death of her parents. We did go ahead with the shock therapy and she gained a moderate relief from her depression and was able to return home. However, little reintegration had occurred.

The third form of therapy, primarily related to symptom reduction, involves the use of certain pharmacologic agents. We do have certain drugs which are of value in the relief of anxieties and fears, others for the relief of depression, and others which relieve elation. Though symptom reduction does not influence the source of the symptoms, it does allow patients to achieve some improvement in adaptation because the symptoms or internalized conflicts interfere to a less extent with the adaptation to reality when influenced by these drugs.

Problems of Transition

With this brief summary of the aims of hospitalization, let us now look at the problems of transition from the hospital to society. Several areas must be explored including the loss of relationships formed while in the hospital, the nonacceptance of the discharged mental patient in his social environment, and the needs for continued therapy.

In the loss of relationships, we must have some awareness of the differences between the hospital environment and the external society to which the patient returns. Within the hospital, activities are arranged for patients and friendships may be established with other patients or with staff members because of the easy availability and continued contact. However, outside of the hospital there are frequently many barriers to the establishment of social contacts. Frequently this is difficult for the well-integrated personality and even more difficult for the mentally ill. In addition, there is generally the severance of therapeutic relationships. The usual response to such severance of relationships is with depression because of the void left when the ego no longer invests energies in these relationships. Further, this separation may be reacted to by anger and melancholia because of the implied rejection when the patient is discharged from the hospital. No matter how long the patient is aware of the planned discharge, he will still view the discharge as a rejection. These feelings will be intensified if the patient has suffered previous loss and rejection and may reactivate the internalized affects and conflicts which the patient has been attempting to reintegrate or repress during the hospital stay. Therefore, discharge from the hospital requires that substitutes for these relationships be established. This can best be done while the patient is still in the hospital so that the transition is less precipitous.

We have found that it is advantageous for the patient to have established contact with a therapist outside of the hospital as well as to have established social and job contacts before leaving the hospital. Such arrangements frequently ease the trauma due to separation from the hospital. However, a certain amount of training is required for the therapist who sees the patient outside of the hospital. All patients have some remnants of feelings toward the hospital and the therapist seen, and these feelings may be of both positive and negative variety. The new therapist, outside of the hospital, must be aware of these feelings which still remain toward the hospital and its staff and must be aware that the separation has been difficult.

Acceptance of the Patient

Our next area of interest concerns the acceptance of the patient by the society to which he returns. The components of this society include the family, the economic or job opportunities, recreational opportunities, and society's attitudes toward the patient with respect to his civil rights.

Families are frequently fearful of the patient's behavior, they may be ashamed of his illness and view this as a "Blot on the Family Escutcheon," they may be angry at him because of his behavior (frequently because he is able to get away with things which they wish to do) or, they may be

overly protective. At times families will not assume appropriate responsibility for patients because of their fear and will not cooperate with other medical agencies because of the fear that the patient will then retaliate toward them. Mental illness still carries a social stigma and families do not like to have it known that one of their members has been hospitalized. Anger and over-protectiveness are similar affects and attitudes aroused with respect to patients with mental illness. Further, families may behave themselves in such manners that they contribute to the illness of the patient and yet will blame all of the problems upon the patient rather than look toward their own involvement in the situation.

Now, it is extremely difficult to change attitudes or reactions on the part of families without involving them in a psychotherapeutic or reintegrative process themselves. More and more, we are recognizing the need for collateral or collaborative psychotherapy with family members in order to allow the patient to achieve his own best level of reintegration. This, however, additionally taxes already over-extended psychotherapeutic facilities, but this need must be recognized in plans for the adequate hospital care and follow-up care of patients.

Another hurdle for the patient is the problem of job opportunities when leaving the hospital. Here there are both economic aspects and ego aspects. Certainly everyone has a higher opinion of himself if he is able to support himself. In addition there is a great deal of ego satisfaction in being able to do something well. Frequently, patients have not had proper training so that they cannot perform well in jobs, and this further adds to their emotional disturbance. In fact, I have been told of some therapeutic programs oriented primarily to the ego support and ego gratifications of learning to perform well in jobs so that rather than being faced with the question, "What am I good for?", the patient then has the satisfaction of knowing that he can perform well in a particular job.

There are varying attitudes of employers, foremen, and other supervisors toward people who work for them and some are not too sensitive to the emotional needs of the people who work under them. In the rehabilitation of the mentally ill, there is the need for more intuitive, understanding employers and supervisors where sensitive patients may feel protected from the generally unsympathetic "Cold, Cruel World."

Further, there are many difficulties in the establishment of social relationships in our present-day society. Even normally integrated people may have difficulty in establishing social relationships and developing a circle of friends. For the mentally ill returning from the hospital, this is even more difficult. Certain social and recreational programs should be established so that the patient has less difficulty in making these contacts. Hospitals should also pay more attention to the social rehabilitation of their patients. Several years ago, one of the psychiatric hospitals developed an interesting program where a social group worker came into the hospital and organized social activities for the patients. Initially, the outsiders had to do all of the organization of the activities, but gradually the patients took over more and more of the responsibility until they, the patients, were planning and giving parties for the visitors. This transition was extremely interesting to watch and is something which should be encouraged for the patient while he is in the hospital.

Further re-adaptation to reality concerns the problems of "Civil Rights." Many patients do have their civil rights withdrawn when they are committed to a mental institution and at times must go through a painful process of having these rights re-established. At times, this re-establishment may require a traumatic court appearance, and the objective and revealing discussions before a court of law sometimes leave the patients with the feeling that they have been "exposed" and have, in some way, become "vulnerable." Further, some states require special procedures for driver's licenses for persons who have been hospitalized in mental hospitals. To my knowledge, there is no data which demonstrates that mentally ill patients are any greater accident risks than the general public. There may be some groups of the mentally ill, such as the anti-social characters against whom society should guard itself, but I doubt that society needs to fear all of the mentally ill.

From this discussion, we can see that there are certain needs in terms of the transition to society. Possibly the transition should generally be made more gradual. The estab-

lishment of social relations before leaving the hospital, a certain amount of re-adjustment to the family while in the hospital, and the acquiring of a job before leaving the hospital, all seem to have beneficial effects upon the transition and make it less abrupt and less traumatic. However, hospitals are crowded and most hospital personnel, as well as patients, wish to make the transition as rapidly as possible. We should further study the emotional reaction of the patient to leaving the hospital since, possibly, much of the patient's wish to leave the hospital rapidly may be related to his own desire to reject the hospital before it rejects him. Other facilities such as follow-up clinics and "half-way houses" would aid in the process of this transition.

Intensive Support Necessary

In conclusion, two additional points should be made. As one sees the development of interest in mental health, we frequently find that there is more interest in educating the public as to the therapeutic aspects of psychiatry and its ancillary sciences but less emphasis upon the amount of money required to support adequate facilities of this nature. Additionally, there is little emphasis on the requirements for teaching programs so that the personnel requirements for psychiatrists, psychologists, social workers, nurses, and others, can be met. At the present time, there is a "sellers market" and many agencies compete with each other to attract required personnel. In actuality, the development of adequate psychiatric facilities throughout the country requires the development of better educational programs for these personnel and our major need is in the support of these educational endeavors. Only through this avenue can we hope to even approach fulfilling the great need which is present.

1220 Dewey Avenue.

VARICOSE VEINS. Varicose veins are due to an inherited vascular weakness and can best be treated by injection therapy with annual checkups for the lifetime of the patient. Surgery is no solution to the problem, emphasizes Dr. H. I. Biegeleisen of New York City. He bases his statement on a 28-year study of 200 patients who had surgery for varicose veins. None showed a permanent cure. "Surgery activates and spreads varicose vein infections causing the formation of lymph legs in half the cases. It has failed to cure varicose veins permanently according to this long-term study," he said. Of the 200 patients studied, 122 were women and 78 were men. Up to the menopause the sexes were operated on in approximately equal numbers, but in the decade after this, women were more numerous. "The influence of childbearing on the development of varicose veins is apparently a transitory one and has probably been overestimated," Doctor Biegeleisen said. Above the age of 60 years more men were treated. Twenty-nine patients had two or more operations. In 189 patients there was complete redevelopment of the original varicose condition following surgery. Many were worse than ever. Prior surgery did not cure or prevent the formation of capillary blemishes. Forty of the patients developed leg ulcers. "Significantly 30 cases were on the same side as the operation for varicose veins . . . The most important complication was the enormous number of lymph legs following surgery . . . 97 cases had developed lymph legs." Injection treatment lost favor primarily because of failure to recognize the chronicity of the condition, Doctor Biegeleisen believes. "Poor results were unfairly blamed on the method rather than on the persistent tendency to new varicose vein formation." Of the 200 patients previously operated on for varicose veins, 127 received a full course of injection treatment with satisfactory results. "The mainstay of the injection method is check-up treatment," the physician emphasized. He now makes it mandatory. Many patients return for only one or two visits a year. "Others learn they can be controlled when they have one-, two-, three-, or even five-year intervals between injection treatments. This maintains the cure in all who are faithful."—BIEGELEISEN, H. I.: End results of surgery for varicose veins, *New York State Journal of Medicine* 60:2386 (August 1) 1960.

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CLINICOPATHOLOGIC CONFERENCE

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CASE PRESENTATION

This patient was originally admitted to the hospital in May, 1952, at the age of 59 years, suffering from cough, dyspnea, orthopnea, slight fever, and ankle edema of unstated duration. There was no record of scarlet fever, rheumatic fever, or diphtheria. His blood pressure was 220/140 and he had a grade II systolic murmur and an early grade II diastolic murmur at the aortic area along the left sternal border. The urine specific gravity was 1.023, it contained 250 mg. of albumin per 100 cc., no sugar, no casts, no red blood cells, a few white blood cells. The blood count was normal. The nonprotein nitrogen was 43; blood sugar, 102; serology, negative. The excretion of phenolsulfonphthalein was 20% over a period of two hours. Considerable widening and elongation of the aorta and considerable myocardial enlargement were seen on the chest x-ray. He had a normal excretory urogram.

The next admission was in December, 1953, when he re-entered the hospital because of chills of three days' duration. Simultaneously exertional dyspnea had appeared. This was accompanied by a squeezing chest pain which persisted only for a few minutes. He had had no ankle edema since he was last admitted to the hospital. He had a persistent slight cough at night. He was cooperative and appeared moderately ill. The blood pressure was 200/120. The apical rate was 80 and regular. The lungs were clear. The heart was regular, and only a grade I aortic systolic murmur was recorded. The remainder of the physical examination was negative. X-ray examination of the chest was essentially unchanged; the transverse diameter of the heart was 18.2 cm. The specific gravity of the urine varied from 1.015 to 1.018; it contained up to 300 mg. of albumin per 100 cc., and many coarse granular casts, many red blood cells, and a few white blood cells. The hemoglobin was 11 gm., red blood cell count 2,750,000. Nonprotein nitrogen was 56; sugar, 92; creatinine, 2.2; phenolsulfonphthalein test at this time revealed 17% dye excretion.

The third admission was one year later in October, 1954. Following his previous admission he had been in fairly good health. He noted dyspnea after walking two blocks and precordial pain on exertion occasionally. This was relieved by rest. He had no ankle edema. On the morning of admission he had a distinct chill and began to be very short of breath. A mild cough appeared, productive of a small amount of white sputum. He complained of pain in the chest wall on the left and in the lower axillary region, both of which were aggravated by his cough. His blood pressure was 170/90; pulse, 108 and regular; respirations, 22; temperature, 103 F. He appeared to be in moderate distress and acutely ill. The skin was hot and moist. The pharynx was slightly inflamed. Scattered rales were heard over the chest on the left side where the breath sounds were increased. The heart was enlarged, normal in rate and rhythm, no murmurs were heard. The liver edge was 2 cm. below the right costal margin. The clinical impression was that the patient was suffering from an acute upper respiratory infection. No evidence of consolidation was seen in the chest x-ray. The transverse diameter of the heart was now 19 cm., as compared to the previous measurement of 18.2 cm. The patient was treated with oxygen, bed rest, and potassium iodine. The specific gravity of the urine varied from 1.014 to 1.020, albumin varied from 180 to 280 mg. per 100 cc. Many red blood cells, and a small number of white blood cells were found from time to time. The tests for sugar and Bence Jones protein were negative. The hemoglobin varied from 9.6 to 10.6 gm.; red blood cell count varied from 3,000,000 to 3,300,000; white blood cell count was 15,000 on admission, later dropped to 5,800. Nonprotein nitrogen varied from 65 to 83; creatinine usually was around 4.5 mg.; serum bilirubin determinations were negative; blood serology was negative. Prothrombin determination was 44% on one occasion and 70% one week later. Total protein was 4.87, albumin 3.6, globulin 1.27; formal gel test was negative; cryoglobulin was present. Several blood cultures failed to show any growth. Sputum smears and cultures revealed a mixed flora with no significant organism; concentrated smears and cultures for tuberculosis were negative. Urine cultures were negative. A phenolsulfonphthalein test showed 6% excretion in one test and 11% in the second. The patient's temperature was 103 F. on admission; 24 hours later it was 98 F.; thereafter it remained in the normal range until he was discharged. The patient improved rapidly and was released approximately two weeks after admission.

The next admission occurred in February, 1955, and was occasioned by the sudden onset of retrosternal and lower chest pain, predominantly left-sided, localized and without radiation. This developed while he was walking. It was persistent. He had become increasingly dyspneic, even at rest; some or-

thopnea had occurred. There had been no anorexia, no diarrhea, and no urinary change. His blood pressure was 198/108; pulse, 108 and regular; respirations, 24; temperature, 101.6 F. He had scattered moist rales throughout the lungfields, most numerous and loudest in the bases. A left-sided murmur, grade I-II, systolic in character, was heard over the entire precordium. The liver edge was palpable two to three fingerbreadths below the right costal margin. There was no ankle edema. X-rays of the chest revealed generalized cardiac enlargement, but the cardiac size had remained unchanged. The urine specific gravity varied from 1.006 to 1.013, albumin varied from 35 to 150 mg. per 100 cc. It contained a few granular casts in all specimens, occasional red blood cells, and a small number of white blood cells. Hemoglobin varied from 10 to 11 gm.; red blood cell count varied from 3,000,000 to 3,500,000; white blood cell count was normal. Nonprotein nitrogen varied from 66 to 124; creatinine, from 4.7 to 5.2; uric acid, 6.9; total protein, 4.05, albumin, 2.9, globulin, 1.15; calcium, 8.4; phosphorus, 7.6; cryoglobulin was again demonstrated in the patient's serum. A phenolsulfonphthalein test done the day after admission revealed an excretion of 5%; repetition of the test in one week showed an excretion of 22%. No residual urine was found. He was treated symptomatically. His temperature rapidly returned to normal. He made a gradual recovery, and was discharged in approximately three weeks.

The next admission occurred in January, 1957. The patient, now 64 years old, felt well after his last discharge until two weeks before the present admission. At this time he again developed an upper respiratory infection. There had been no dyspnea, no ankle edema, and no chest pain. He had been on digitalis, one tablet every other day. In the interval, he had lost some weight, so that he now weighed 130 lbs. as contrasted with a weight of 180 lbs. some four years before. His blood pressure was 150/80; pulse was regular; temperature, 98.6 F. He appeared chronically ill. He had lesions of acne and furunculosis over his back and shoulder. The optic disks were flat and fairly well defined, the retinal arterioles were spastic. The chest was clear. The heart was slightly enlarged to the left; no murmurs were heard. The liver, kidneys, and spleen were not palpable. No edema was found. X-rays of the chest were essentially unchanged from those on the previous admission. The urine specific gravity ranged from 1.005 to 1.010, albumin varied from 30 to 75 mg. per 100 cc. It contained no sugar, but a few granular casts were found. There were many red blood cells in one specimen, and occasional white blood cells were seen. The hemoglobin was 4 gm. on admission; red blood cell count 1,190,000; white blood cell count 2,300, with 47 segments, 1 stab, 44 lymphocytes, 2 monocytes, 5 eosinophils, and 1 basophil. Some stippling, anisocytosis, and poikilocytosis were found. Hematocrit was 12; mean corpuscular volume, 100; mean corpuscular hemoglobin, 33. Nonprotein nitrogen was 130; creatinine, 6; two-hour postprandial blood sugar was 156; total protein, 5.08; albumin, 3.67; globulin, 1.41; calcium, 9; phosphorus, 5.25; and no dye was recovered with the phenolsulfonphthalein test. On a Rosenthal concentration test the urine specific gravity varied from 1.009 to 1.011. Bence Jones protein was negative. Electrophoresis showed albumin 62.4%; alpha 1—5%; alpha 2—15%, beta—12%; gamma—5%. Because of the leukopenia and the severe anemia, a bone marrow examination was performed. This showed that the marrow was moderately cellular with large areas consisting of sheets of typical plasma (myeloma) cells. The patient was treated with blood transfusions and supportive medications. During the hospitalization a carbuncle appeared which was treated by x-ray therapy and novobiocin (Cathomycin). The patient gradually improved to the point where he could be discharged approximately three weeks after admission.

The final admission occurred two weeks after this discharge from the hospital. On admission he was comatose. His temperature was 104 F.; blood pressure was 180/88. Physical examination was essentially unchanged. The liver was recorded as being barely palpable. There was no edema. He died within 48 hours of admission. No laboratory or x-ray work was done.

Discussion

Dr. Robert A. Kebbekus (Discussant): In reading the protocol, it is apparent that this represents multiple systemic disease involving the renal, cardiorespiratory, and hematologic. Most significant is the progressive renal insufficiency.

This 59-year-old male was first admitted in May, 1952, presenting predominantly cardiorespiratory and renal findings. Admission was for cough, fever, dyspnea, and edema. Interestingly, this is the only mention of edema. He had hypertension with elevated systolic and diastolic pressures, apparent aortic valvular involvement, cardiomegaly, and good urine concentration with specific gravity of 1.023. There was albuminuria and this was the only admission without hematuria. Slight azotemia was present with a normal intravenous pyelogram. However, at this early date, there was very poor renal tubular excretion of the phenolsulfonphthalein dye. It is not known whether his hypertension preceded the urinary findings. It would be valuable in the determination of nephrosclerosis.

His second admission occurred a year and one-half later. This is the first in a series of admissions in which the patient entered the hospital with an acute illness described as an upper respiratory tract infection which rap-

idly subsided, revealing an underlying renal insufficiency. He was admitted this time with chills, transitory chest pain, and night cough. It is noted that there is no history of rheumatic fever, scarlet fever, or diphtheria. However, 50% of patients with rheumatic heart disease do not give histories of rheumatic fever. Blood pressure was 200/120 with an aortic systolic murmur. There was a drop in the specific gravity of the urine accompanied by albuminuria, hematuria, and pyuria. Phenolsulfonphthalein excretion diminished to 17%, suggesting either a decreased renal blood flow or perhaps damage to the tubules with decreased tubular excretion. The findings of chest pain are suggestive of angina pectoris. The chills and urinary findings may indicate acute pyelonephritis. However, we have no history of dysuria or flank pain. We could also be dealing with an acute glomerulonephritis at this time.

In October, 1954, the patient was again admitted with chills, fever, precordial pain, and a cough productive of sputum suggestive of another upper respiratory tract infection. Rales were heard over the chest on the left side, but x-ray was normal except for cardiomegaly. There were no murmurs recorded. Renal findings were those of an increasing insufficiency, i.e., albuminuria, hematuria, and azotemia. Bence Jones protein was absent from the urine. Phenolsulfonphthalein excretion on his third admission was 6% which is a considerable decrease in the excretion of the dye. Urinary cultures were negative. Determination of the residual urine was within normal limits which is significant for lack of obstruction. Hypoproteinemia and cryoglobulinemia were noted. Cryoglobulins are present in small amounts in a variety of diseases and in significant amounts in multiple myeloma. Myeloma has been found in 50% of patients with definitely elevated cryoglobulins and associated symptoms. This admission, although it was a transitory acute episode, emphasized the fact that this patient suffered from an insidious, rapidly increasing renal insufficiency.

The fourth admission was four months later. The patient arrived with chest pain, dyspnea, orthopnea, and fever. Again there was a rapid recovery after the infection. With hypoproteinemia of 4.05 and albumin of 2.9, it is surprising that an edematous state was not manifest.

The next to final admission was two years prior to his death. He again was admitted with an episode of acute respiratory tract infection. Retrospective over a period of four years, he lost 50 pounds and the effects of chronic illness were becoming manifest in his appearance. It is notable that the blood pressure was within normal range—an instance of renal insufficiency without hypertension—in essence, a fixed urine specific gravity ranging from 1.010 to 1.015; nonprotein nitrogen was 130; again a hypoproteinemia and a phenolsulfonphthalein excretion of no dye whatsoever. Snapper and others have emphasized that normotensive azotemia should prompt a search for multiple myeloma.

In view of the finding of multiple myeloma on bone marrow biopsy, one is very tempted to ascribe the anemia to myelomatous involvement of the marrow. The electrophoretic pattern demonstrates low gamma globulin and slightly elevated alpha-2 globulin. Alpha-2 globulin myelomatosis is rare and doubted by some. Owen restricted the classification to those cases in which alpha-2 globulin exceeded 20% of the total serum protein in uncomplicated cases. The electrophoretic pattern revealed 15.5%, although this does not exclude the specific diagnosis since there appears to be other complicating renal disease.

Perhaps the hypoproteinemia and hypogammaglobulinemia can be explained on the basis of the advanced renal insufficiency of chronic nephritis. The bone marrow is reported as containing many typical plasma cells and is indisputable evidence of multiple myeloma. They are proliferating in sheets which, of course, supports the diagnosis of myeloma.

The terminal admission was two weeks later.

May I see the x-rays at this time?

Dr. John L. Armbruster: The pyelogram was probably a normal excretory urogram. The function of the kidneys was not good. Air and fecal material, of course, were in the way, which is not unusual. However, there was function of each kidney. There was no evidence of obstruction as far as the excretory urogram was concerned.

We have films of both kidneys. The retrograde film was recommended but never done.

In 1952 his chest film showed cardiac enlargement, slightly tortuous aorta, some widening and old pleural adhesions in the

left base. There was nothing remarkable in either lung field.

The repeated chest films, over the period of years, were all about the same. On his last admission in January, 1957, there was no remarkable change. There was some density in the superior mediastinum which is a "red herring," as I do not believe it is due to any retrosternal extension of the thyroid but rather to the kyphosis of age. The hilar vascular markings remained about the same. There was one peculiar shadow just beneath the aortic knob which, I believe, is nothing more than pulmonary artery, although we have seen chests looking even more normal than this which later proved to be carcinoma of the lung.

I can say there is nothing more than cardiomegaly and old pleural adhesions.

At this time, despite the fact that there were myeloma cells in the bone marrow, I would like to ask just who thought of doing a bone marrow examination and why? A KUB examination as just a bone survey of the pelvis and lumbar spine reveals no evidence of any bone destructive lesions similar to those you find in myeloma, although we must admit that the bone changes probably occur late in cases of myeloma.

The skull film revealed two small radiolucent areas on each side of the midline which were probably venous lakes or pacchyonian impressions. The x-rays were noncontributory except for cardiac enlargement.

Doctor Kebbekus: The electrocardiograms show left ventricular hypertrophy, possible subendocardial ischemia, and first degree AV block. This supports the x-ray and physical findings of cardiomegaly.

We are dealing, then, with *advanced renal disease.* The clinical picture may be caused by several types of bilateral renal processes, all characterized by what we have seen in this particular case; excretory failure, progressive uremia, hypertension, cardiomegaly, and vascular retinopathy. The initial process could be one of three: glomerulonephritis, pyelonephritis, or nephrosclerosis. In the terminal phase, it is almost impossible to distinguish them.

Let us consider each of these to see if we can arrive at a sound, etiologic basis for this case.

We do not have the natural history of *chronic glomerulonephritis* in this particular case. However, there occasionally is no antecedent history of initial streptococcal infection followed in a couple of weeks by clinical glomerulonephritis, followed by recurrent episodes of kidney disease. In chronic glomerulonephritis we see, typically, albuminuria, hematuria, casts, hypertension, edema, decrease in serum protein, and no urinary obstruction. Usually these people are made worse by upper respiratory tract infections but are better on bed rest alone. The episode in 1952 may have been an attack of acute glomerulonephritis, although the patient is a little bit old for this particular disease process. This does not rule it out, however.

In *chronic pyelonephritis* the initial onset is with acute chills, fever, flank pain, dysuria, white blood cells, red blood cells, and bacteria. Throughout the patient's entire life, as far as we know, there had never been a positive urine culture. In every instance, there were only a few white blood cells at the most. In most cases there is urinary obstruction although infection may be blood-borne at times.

Chronic pyelonephritis is characterized by repeated acute attacks. We usually find evidence of prostatic obstruction, congenital anomalies or, perhaps, renal calculi. This is not true in this case. The intravenous pyelogram showed no obstruction. Although progressive uremia is very characteristic, hypertension is not as frequent with pyelonephritis as it is with glomerulonephritis.

Considering *nephrosclerosis,* an antecedent history is desirable because in arteriolar nephrosclerosis, one usually finds the appearance of hypertension before the urinary findings. The urine shows the nonspecific findings of arteriolar nephrosclerosis, mainly albuminuria and hematuria.

Tuberculosis must be considered, although there is very little evidence to support this diagnosis. Usually, this is an insidious disease characterized by hematuria alone. The chest x-rays do not indicate any active pulmonary process. Urine cultures were negative for tuberculosis. Summarily, we may dismiss tuberculosis.

Another consideration, in view of the prolonged chronic infection with which we are dealing, is *amyloidosis.* A Congo-red test was not done. In amyloidosis, hepatomegaly and splenomegaly without hypertension is observed and occasionally a nephrotic syndrome will occur.

Briefly, in collagen diseases, we would expect to find other systemic manifestations of collagen disease and occasionally one sees a nephrotic syndrome with disseminated lupus. Typical urinary findings in lupus erythematosus are albuminuria and cellular casts. We do not have enough evidence to consider collagen disease.

Are we dealing with *multiple myeloma* entirely, or with multiple myeloma plus glomerulonephritis, pyelonephritis, or nephrosclerosis? Separate identification is difficult.

If we are dealing with multiple myeloma alone, we should expect an increase in the total protein. It is suggested that the increased albuminuria throughout this patient's documented history has been the cause of the decrease in his blood protein. In multiple myeloma, the onset of renal disease is usually after the age of 50. It is a tubular obstructive phenomenon. It is not certain why the obstruction appears and whether it is a myeloma per se or whether it is due to the protein which these patients put out, but albuminuria is a very common finding. The Bence Jones test is positive in 20% to 80% of the instances, depending upon whose series you are reading. It is generally agreed that it occurs in about two-thirds of the cases of multiple myeloma. Hypertension is not frequent and, as indicated, the plasma proteins are usually increased. It would seem more than one factor is working here, i.e., we are dealing with a nephritis in addition to a myeloma in that we do not have the typical findings of a myeloma alone. The prominent symptom of myeloma is bone pain and we have had chest pain here, although x-ray failed to reveal a lesion in the ribs. The patient's weight loss is also characteristic of multiple myeloma. Hepatomegaly is present which might also be due to congestive heart failure. Anemia is present in 90% of patients with multiple myeloma and frequently to a severe degree in the terminal phase. It is usually normochromic anemia. It is also common in chronic renal parenchymal disease; severe anemia is not usual in obstructive uropathy.

Bone marrow is necessary for the unequivocal diagnosis of multiple myeloma, especially if we determine that we have sheets of myeloma cells, which was true in this particular instance. Reiterating, in typical multiple myeloma there is elevation of the serum protein, mainly due to an increase in the globulin fraction, which we did not have here.

Summarizing, we are dealing with a far advanced renal disease. I believe this is chronic glomerulonephritis in addition to multiple myeloma. There are questionable aortic and mitral valvular lesions. I believe the patient died of uremia and possibly septicemia.

Dr. Erwin S. Huston: I think that Doctor Kebbekus has discussed the case very well. From the clinical standpoint, during the time that I observed this patient, the problem was primarily that of a chronic nephritis with anemia, uremia, and infection. The reason for examining the bone marrow was the marked anemia and leukopenia. The finding of many plasma cells was a surprise to me, I must admit, but in view of the eventual clinical picture, the diagnosis of multiple myeloma certainly fits. The problem that we faced in treatment was mainly that of supportive measures and the problem of infection.

Dr. Edward A. Birge: Before we discuss the matter of the autopsy and what we found, I wonder if there are any questions?

Dr. David J. Lafond: Is there any correlation between the cryoglobulins and the low gamma globulin, as reported by electrophoresis, and the apparent absence of myeloma proteins?

Doctor Birge: There is no correlation.

Dr. R. Parks LeTellier: There are very few of the classical findings present here to make a diagnosis of multiple myeloma. However, the hypogammaglobulinemia would add some statistical weight to that diagnosis. Secondary agammaglobulinemia is confined to neoplasms of the lymphocyte-plasmacyte series of cells, namely lymphoma, lymphatic leukemia, and multiple myeloma. For example, secondary agammaglobulinemia has not been found in association with myelogenous leukemia. The hypogammaglobulinemia together with the sheets of plasma cells in the bone marrow certainly gives added support to the diagnosis of multiple myeloma.

Doctor Birge: I might say in passing that when we reviewed our cases of multiple myeloma, we found that approximately 25% of the cases were not diagnosable by x-ray, the radiologist's diagnosis being either nor-

Fig. 1—Microscopic section of kidney (35x).

Fig. 2—Microscopic section of vertebral bone marrow (115x). The discrete nodules are composed entirely of plasma cells.

mal bones or generalized osteoporosis. The punched-out areas in bones apparently represent a fairly far-advanced stage of the disease and may be absent in the early case.

The autopsy was done quite promptly after death. There was an extensive bronchopneumonia which undoubtedly was the immediate cause of death. The heart was enlarged, weighing 500 gm. There was no evidence of any valvular abnormality, and I should add that the various murmurs which were heard were those recorded by the interns. The liver was slightly enlarged. The spleen weighed 275 gm. which is moderately enlarged. The kidneys were moderately diminished in size and weighed 125 gm. each. They had a rather fine granular external surface and the capsules stripped with some increased difficulty.

This fine granular appearance is more in keeping with the diagnosis of chronic glomerulonephritis than with chronic pyelonephritis. Chronic pyelonephritis is characterized by a coarser granularity and U-shaped scars. However, one must realize that there are considerable variations in biological material.

Microscopically (Fig. 1) the predominating change was one of interstitial fibrosis. This shows that although the reduction in weight had not been great, the reduction in actual functioning capacity of the kidney had been tremendous. Very few glomeruli were unaffected and capable of functioning. Most of the parenchyma was composed of scar tissue with a few areas in which enlarged, lobulated glomeruli were found. These were associated with small nests of dilated tubules. The bulk of the kidney had been replaced by fibrous tissue which showed a diffuse lymphocytic and plasma cell infiltration. No leukocytes were found. The tubules in the fibrotic areas were small, contracted, and extremely atrophic, and the glomeruli were completely fibrosed. It shows further that in areas where the glomerulus had not been completely destroyed, the pathologic change appeared to consist of a uniform fibrous thickening and contraction of Bowman's capsule with diffuse concurrent fibrosis of the glomerular tufts. Rarely one finds a few delicate intraglomerular adhesions. There was some increase in the number of glomerular nuclei but this was not excessive. The glomerular capillaries were usually thin-walled. The thickening of the glomerular tufts was the result of a diffuse fibrosis which was very well brought out by special stains. There was intimal thickening of the smaller arteries and some of the arterioles showed both thickening and hyalinization of their walls. These changes were not those of a true arteriolar sclerosis but were secondary in nature.

The diagnosis rests between chronic glomerular nephritis and chronic pyelonephritis. This differentiation is not always an easy one to make. The latter condition has received considerably more attention in the past few years than it has previously. It is now thought that it occurs much more commonly than we had believed in the past. The absence of acute urinary symptoms and the inability to culture organisms on the one occasion described would not invalidate this diagnosis. Chronic pyelonephritis is characterized primarily by a diffuse fibrosis and inflammation such as one sees in this particular kidney. Glomerulonephritis is also characterized by fibrosis, but fibrous adhesions between the glomerulus and Bowman's capsule are more numerous and prominent than in these sections. In the absence of a history of a true glomerulonephritis, and in the absence of any of the usual diseases which are often followed by nephritis, such as rheumatic fever or scarlet fever, I believe that the most probable diagnosis would be a chronic pyelonephritis lenta.

The second clinical diagnosis was multiple myeloma. The changes in these kidneys are not characteristic of multiple myeloma. In multiple myeloma the changes are primarily tubular and consist of occlusion by precipitated Bence Jones protein. These casts may give rise to a foreign-body type of reaction in the parenchyma. The glomeruli are relatively unaltered.

Sections of vertebral bone marrow (Fig. 2) show a moderately cellular tissue with multiple small tumor nodules such as one sees in multiple myeloma. Sections of rib marrow also contain many of these little tumor nodules. They are not confluent yet, but they did form 80% of the cells found in our aspirated smears. The nodules are composed of plasma cells. I believe that these are of neoplastic origin rather than inflammatory, although this cannot be proved with objective certainty. Plasma cells do increase in chronic infections. The absence of elevated proteins and the absence of the myeloma protein are not against a diagnosis of multiple myeloma. In all of the larger reported series, one finds that there are a few cases in which the total proteins are normal. In more recent reviews, where electrophoretic studies were made, the electrophoretic pattern in such cases also is essentially normal. I can only comment on the problem of Waldenström's syndrome. I know of only one way in which it can be diagnosed absolutely, and that is by the use of the ultra-centrifuge, which was not available to us.

In summary, then, I feel that we are dealing with an individual who had two conditions. His primary condition was that of a chronic pyelonephritis lenta. The second condition was multiple myeloma, which I believe was just beginning when he died. This would account for the paucity of changes in the serum proteins.

2200 West Kilbourn Avenue (3).

one of a series

ROENTGEN RIDDLE . . .

HISTORY: An 18-year-old colored male entered the hospital because of an abnormal pre-employment chest x-ray.

PHYSICAL EXAMINATION: Negative.

LABORATORY FINDINGS: Studies for blastomycosis, coccidioidomycosis, histoplasmosis, and tuberculosis were negative; although the calcium was elevated, and there was a reversed albumin-globulin ratio.

X-RAY: The mediastinum revealed bilateral, symmetric, irregular widening. The lateral borders of this density were generally smooth and presented a scalloped appearance.

Prepared by Alphonse Richter, M.D., resident in radiology at Milwaukee County Hospital, under direction of John R. Amberg, M.D., radiologist, Department of Radiology at Milwaukee County Hospital.

SEE DISCUSSION ON PAGE 150

Why Fluoridate?

By MICHAEL C. ARRA, D. D. S.
Madison, Wisconsin

A MILLION or so Americans were losers in last fall's election. Their communities said "no" to fluoridation of the public water supplies. Among them were approximately 42,000 in four Wisconsin cities and villages which held referenda.

The question: "why fluoridate?" is not difficult to answer, either from the standpoint of the present picture of dental caries among all adults and among children in nonfluoridated areas or from the standpoint of the reduction in decay where the water contains adequate fluorides. The hard question to answer is why some communities reject this public health measure.

Let's briefly review the problem first. Tooth decay is the most prevalent of all diseases, being costly, painful, and disfiguring. Nature has provided no means of self-healing or regeneration. Nationally, it is estimated that 97 per cent of the American people are affected by dental decay and have approximately 700 million untreated cavities —an average of nearly four per person.[1] The U. S. National Health Survey conducted in 1957–58 showed 22 million persons or 13 per cent of the total population to be edentulous.[2] The survey also showed that by the time a person reaches 65 his chances of retaining all or even some of his teeth are very slim, as nearly everyone will be without teeth. These findings simply reinforce those of World War II when 10 per cent of the first two million draftees were rejected because they did not have twelve opposing teeth.[1]

In Wisconsin the dental picture parallels that of the nation. In addition, we have found that only 40 per cent of the state population seek adequate dental care; 30 per cent seek occasional dental care for relief of pain or extractions; and the last 30 per cent do not receive or seek dental care.

These dental health problems are far from being restricted to adults. Data based on the examination of 40,000 Wisconsin school children in nonfluoridated areas showed these results:

Deciduous Teeth

Age 3	d.e.f.* rate 1.5
Ages 5–6	d.e.f. rate 5.5

Permanent Teeth

Age 6	D.M.F.** rate 1.0
Ages 9–10	D.M.F. rate 4.0
Ages 12–14	D.M.F. rate 10.0

Wisconsin has approximately 150 communities with adequate fluorine content in their public water supplies representing approximately 73 per cent of the population served by the public water supplies. Among them is Sheboygan where fluoridation began in 1945. Other communities show results similar to those in Sheboygan, where studies consistently disclose that adequate fluorine content in drinking water results in as high as 65 per cent reduction in tooth decay for children who have used the fluoridated water for 6 years or more from the time they were born. Table 1 summarizes the Sheboygan results:

TABLE 1—*Results of Fluoridation at Sheboygan*

Grade	Survey Made Before Fluoridation	Survey Made After 12 Years Fluoridation	Per Cent Improvement
Kindergarten (ages 5–6)	4.80 d.e.f.	1.66 d.e.f.	65.4
4th Grade (ages 9–10)	3.03 D.M.F.	1.36 D.M.F.	55.1
8th Grade (ages 12–14)	8.54 D.M.F.	3.98 D.M.F.	53.4

With the seriousness of the dental health problem—and a proven, safe preventive measure available—why do some communi-

Doctor Arra is Director, Division of Dental Health, State Board of Health.

*d.e.f. refers to the caries-attack rate in *deciduous teeth;* that is, the average number of decayed, extracted and filled *deciduous teeth* per child. The d.e.f. rate is determined on the kindergarten age group only and it is obtained by dividing the sum total of d.+e.+f. teeth by the total number of children.

** D.M.F. refers to the caries-attack rate in *permanent teeth;* that is, the average number of decayed, missing and filled *permanent teeth* per child. The rate is determined by dividing the sum total D.+M.+F. teeth by the total number of children.

one of a series

Medical Stamps

JANE ADDAMS (1860–1935)

Best known as a sociologist and philanthropist. Is included in collections of physicians and medical subjects because she went to the Woman's Medical College, Philadelphia, for a year, leaving because of ill health. She then became interested in social reforms. Travelled extensively in the United States and Europe. She is best known for the establishment of Hull House in Chicago (1889) in the heart of the slums where the poor, including many immigrants, were given chances for recreation and education. She supported movements for social reforms and was interested in peace projects. Received the Nobel Prize in 1931. Here she is shown on U.S. #878, also portrayed on Turkey #B62.

HARTMAN V. SCHEDEL (1460–1541)

A physician who wrote the Nuremburg World History in 1493; name inscribed on the stamp which is a reproduction of an illustration from his book. Poland #73.

* * *

ACKNOWLEDGMENT: Reproduced by permission of Oscar Gottfried, New York City, author of "Doctors Philatelic," bibliography of nearly 300 illustrative medical stamps, which is available at $3.00 from The New York Physician, 1440 Broadway, New York 18, N. Y.

* * *

Physicians interested in obtaining medical stamp displays for exhibit purposes, write Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin.

ties continue to reject adoption of fluoridation? There are many contributing factors. For one, the people in communities that traditionally adopt new health measures accepted fluoridation in the early years of promotion; the more conservative have waited to take this step as they have waited to put in public water supplies, construct sewage systems, or adopt milk ordinances.

There are some sincere opponents who feel that fluoridation invades their individual rights. Some simply do not understand either the problem or its solution and are easily swayed by false statements which arouse fear or resentment. A few, perhaps, take advantage of this issue as they would of another for personal gain. In recent years, the opposition with all its varying objectives has organized and moved into any community considering fluoridation with high pressure persuasion techniques. This organized opposition has been all too effective as election results disclosed last fall.

Arthur S. Flemming, while secretary of the Department of Health, Education and Welfare, appropriately stated: "A gross disservice is being done the children of America by a small, militant and for the most part demagogic group utilizing unscientific arguments to influence communities against fluoridation. All of the blame for the lag in fluoridation, however, must not be placed on the shoulders of the uninformed who for various reasons are opposed to it. Some of the blame must be shared by those of us who are informed, who have seen the evidence, who know the benefits and who yet have not worked hard enough to bring about the adoption of this wholesome public health measure by our home communities."

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Editors
HARRY BECKMAN, M. D., Marquette University
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Choice Among Thyroid Compounds

By HARRY BECKMAN, M.D.
Milwaukee, Wisconsin

THYROID SUBSTANCE is the desiccated and powdered thyroid gland of food-providing domesticated animals. It is not bioassayed but rather adjusted to meet U.S.P. requirements according to its content of iodine in the form peculiar to the gland. Thus thyroid substances of a considerable range of potency are possible, though actually the two in greatest use are thyroid U.S.P. and Thyroid Strong (Parke–Davis), the latter containing half again as much iodine as the former and hence having half again as great potency.

Sodium Levothyroxine (Synthroid), 3,3',5,5'–tetraiodothyronine pentahydrate, the sodium salt of the levo isomer of thyroxin, is a synthetic compound that does not require standardization.

Sodium Liothyronine (Cytomel), sodium 1-triiodothyronine, presumably the physiologically active isomer of triiodothyronine, is also a synthetic compound.

The same effects can be obtained in hypothyroid states with sodium levothyroxine (Synthroid) as with thyroid substance, but experience with the drug is still relatively limited and it has no apparent advantages over the natural product for continuous maintenance use. Much time will probably be required to break down the prejudice against levothyroxine because its predecessor, racemic (dl) thyroxin, was not reliably absorbed and was very expensive.

In a series of articles published since 1958, Starr and associates[1,2] have been presenting sodium dextrothyroxine (Dextroid) as having therapeutic usefulness in all forms of hypothyroidism, particularly in cases complicated by heart disease. It is said by this group of investigators that the drug has the ability to maintain normal oxygen consumption in dosage which reduces serum cholesterol without stimulating the heart through catecholamine synergism; in other words, that it will reduce hypercholesterolemia to "normal" without raising the basal metabolic rate or increasing the pulse rate. With this drug, therefore, one would be able to lower the hypercholesterolemia of euthyroid individuals without provoking the side effects that make the use of sodium levothyroxine or of thyroid substance itself unsatisfactory for the purpose. Full confirmation of Starr's findings by other workers will be awaited with interest. The early animal studies of Reinecke and Turner[3] in 1945 revealed no potency for the compound, but Starr[2] in 1960 reported that substitution therapy in athyreotic rats is effective if the dosage is tenfold that of levothyroxine.

Sodium liothyronine has a short duration of action in comparison with thyroid substance and levothyroxine, and its omission often causes distressing withdrawal symptoms. It is difficult to see how it could ever be useful in the routine treatment of myxedema or cretinism. Of course, if a myxedematous patient needs the rapid and powerful action it can provide, in order to be saved from death, then its use would certainly be indicated; but this could hardly be called a "routine" situation. In recent years there have been a number of published studies of the use of the drug in the malady that has become fashionable under the title of "hypometabolism," which is presented by the supporters of its existence as a state of affairs in which a patient has the fatigue and a few other things suggestive of myxedema but cannot be diagnosed by the reliable criteria of that state—which appears to numerous observers to be just a new description of neurasthenia. At any rate, there have been

descriptions of fair results achieved with this drug in patients of this sort who had not responded to the use of thyroid substance in usual dosage. When well controlled studies will have shown that this was more than a placebo effect, one will have to begin to believe in it.

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Roentgen Riddle continued from page 146

DISCUSSION: The chest film reveals the typical findings of mediastinal adenopathy. Hilar nodes are not ordinarily seen on a normal chest x-ray and their description as being enlarged is quite nondiagnostic. Sarcoidosis was entertained as the most likely diagnosis because of the complete lack of any symptoms.

Neoplasia, primary or metastatic, and inflammation are prime considerations in the differential diagnosis. Of the former, lymphomas, such as Hodgkin's disease, lymphosarcoma or leukemias are statistically greater than metastatic disease of the esophagus, lungs or trachea. Inflammatory disease generally presents a more difficult differential. Erythema nodosum and infectious mononucleosis are common acute disorders resulting in a similar x-ray picture. Chronic granulomatous diseases include tuberculosis, the mycoses, and brucellosis. The history, physical and routine laboratory studies do much to guide one.

The diagnosis of sarcoidosis today is essentially one of exclusion coupled with a positive biopsy (skin, liver, muscle, lung, marrow and node). Even a positive biopsy is not pathognomonic, for similar histological findings of epithelial tubercles with giant cells and without evidence of necrosis are present in beryllium poisoning and histoplasmosis. The Nikerson–Kveim skin test has been used but is quite cumbersome and time consuming.

Etiology remains a mystery. Present day investigations are considering sensitivity factors such as calcerous spar in the soil or pine pollen of Eastern United States. Hyperglobulinemia, which has been shown to be present in 88% of the cases, may lend support.

Since the disease is systemic, one might expect other manifestations to occur or exist and so they do. Nodular skin lesions, uveoparotid fever, juxta-articular punched-out lesions of phalanges, and splenomegaly are the most common.

The chest roentgenogram of the present patient exhibits one of the three gross types as described by Garland. Interstitial nodularity or thickening with or without hilar adenopathy are the remaining forms. The course of the disease clinically is quite nonspecific. Low grade fever, fatigue, myalgia, and slight cough are said to be present intermittently. The general roentgen course is that a height of infiltration is reached and then gradual interstitial fibrosis. This course of events runs from 2 to 10 years.

Though in the past considered a benign disease, Veterans Administration's statistics point to the morbidity of emphysema, pulmonary hypertension and cor pulmonale. Further, they state, of 540 cases diagnosed as sarcoidosis over a two-year period, 15%, or 84 patients, died within five years.

The President's Page

THE NEW FRONTIER

AS OF JANUARY 20th, this nation embarked on a journey into the New Frontier. As with previous eras, we are again wondering what vistas will open before us, and what stumbling blocks we may encounter on the road ahead. This great nation has always gone forward with a determination, and progress has been the inevitable result. I am confident that history will again repeat itself, and that we shall again emerge from these frontiers, as the butterfly from its cocoon.

For medicine, there are crucial days ahead. Days that are going to require our daily and united efforts and attention. It has been said, "Do not ask what your country can do for you; but, what you can do for your country."

Gentlemen of the medical profession, I see this statement as a challenge. A challenge for us to maintain our position as proponents of the voluntary methods of caring for our people, young or old, as we have for the past century and a half; without dictation; with freedom of choice, and the fine and close relationship that should exist between doctor and patient.

Let us not falter in accepting this challenge. Let us go on with renewed fervor, and with a determination to retain a position of freedom for all of the people of this great land of ours, and for an honored profession that has always served, day or night, with the benefit of mankind as its guiding star, and the reward many times not forthcoming until the Last Frontier is crossed.

Doctors of the State of Wisconsin, and of the nation, this is literally a *Call to Arms*. We must close our ranks, and present a united front. Let us "*do for our country*" all that we can; let us not fall into that apathetic state that permits government to do for us that which we can do for ourselves, and do much better. Let us keep our eyes focused always, and above all, on the preservation of our liberties, and our freedoms, which constitute our most precious heritage.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Partial Privilege

NOT TOO LONG ago, a furore was created when a University of Chicago study group tape-recorded the deliberations of juries in an effort to improve the jury system. In this relatively innocuous context, which is certainly not supported by any legal sanction, the right of privacy was vigorously defended by both newspapers and lawyers. Subsequently, in a widely publicized case, a woman reporter chose a jail sentence for contempt of court rather than reveal the sources of information which became involved in a libel suit. She won the admiration of the American press, and her action was applauded by people who value personal individual integrity as a cornerstone of political democracy.

We wonder, therefore, why the sanctity of a man's own skull is less respected when he changes his mind about his political allegiance. Why should the confidence a patient gives his psychiatrist have any less validity than that which a client places in an attorney or a parishioner entrusts to a priest? Although the privileged character of medical confidences has no universally recognized legal status, it has the force of long-standing custom and the logic of analogy. It must be considered as an aspect of the right of privacy, and its violation is an abridgment of the integrity of the individual.

The case in point is the testimony of a Dr. Clarence Schilt before investigators of a House of Representatives subcommittee looking into the defection of two employes of a national security agency. The nation was horrified that the two men working in critically sensitive intelligence jobs were able to leave the country and carry secret information to the Soviet Union.

Doctor Schilt undoubtedly thought he was performing a service by disclosing to the investigators that one of the turn-coats had a history of emotional problems that would explain personal instability, and to support his contention, he detailed confidences his patient had given him. This information enabled superficial pundits to conclude that the two traitors were merely mixed-up characters, and if you simply looked inside *any* man's head, you could find out—if you had the skill—whether he is going to be a loyal worker or a foul-ball.

The fact that the two men in question may have been pawns of an enemy apparatus is glossed over. Also overlooked is the much more likely possibility that the two men underwent an ideological transformation which turned them from loyal citizens into enemy agents. To admit the latter is to force an examination of our own political ideology, and few congressmen would undertake that kind of a task in an election year.

So, the investigation triumphantly demonstrated that the two men were emotional cripples; and after all, what can we expect of chaps who do not feel as we do about family, church, sex and The Bomb. And this brings us back to the issue of personal privacy.

If a government agency wants to poke around in the subconscious of every candidate for a national security job, it is, of course, within the right of the agency to do so—as it is the right of any private concern to indulge in psychological testing—provided the candidate is willing to submit to such probing. In that case, there is a voluntary surrender of the right of privacy and that surrender is also a privilege of the individual. But if an individual is indicted for a crime against our national security, his emotional problems have no bearing on his guilt or innocence. There is no such thing as second or third degree treason. If he is guilty, his psychopathology makes no difference. If he is innocent, he can prove his innocence on palpable facts alone.

An American is safe in his home, in the possession of property, and in the integrity of his person, except by due process of law. The law, fortunately, applies to all. If a man is entitled to privileged communication with his lawyer, he keeps his right whether he is a True-Blue One Hundred Per Center, or whether he is a Benedict Arnold who thinks God's country is elsewhere. And if he is entitled to privileged communication with his lawyer in an episode of personal hazard, he is surely entitled to privileged communication with his doctor, particularly when violation of privacy does not affect the crime or its consequences.

Doctor Schilt may have practiced in a state which does not legally recognize the privileged character of communication between doctor and patient. If this is true, Doctor Schilt's testimony, while permitted under the law, was a matter of his personal decision and relates to his code of professional ethics. Perhaps he thought that the right of a Congressional subcommittee to information transcended the right of his patient to privacy when national security was involved. In any event, the occasional abridgment of the right of privileged communication between doctor and patient must be condemned—whether for legal or ethical reasons.

Only by the strict maintenance of the highest principles of professional behavior can we uphold the integrity of our profession. As physicians, we cannot condone any action that allows the establishment of levels of rights.

GUEST EDITORIAL

Medicine at the Crossroads

EDITOR'S NOTE: Dr. John Allen, in his position of medical consultant to the State of Wisconsin Department of Public Welfare, is probably as highly attuned to the importance of the physicians' public image as any doctor around. His energies are devoted to the creation of effective accord between public officials and practicing physicians, an effort sometimes as frustrating as it is challenging. He has visited a great many county medical societies, speaking on various aspects of the medical programs of the State Department of Public Welfare. Out of this activity has evolved the timely message in the guest editorial that follows.

* * *

DOCTOR, when you look into the mirror, what do you see? If you are like the vast majority of physicians in this country, you see a highly trained, dedicated medical man, aggravated by an increasing load of paper work and nonclinical detail, but yet very concerned because you feel medicine is apparently losing the battle of medical public relations.

Most physicians would be content to restrict themselves to caring for their patients and leave to someone else the responsibility of completing the remainder of the medical profile. People outside of the medical profession have done much of this work for us, these have included government officials, advertising men, attorneys, politicians and the

like, when actually there are physicians trained, skilled, and interested in medical administration and legislation that should be in the command role, guiding medical public relations and administration.

Perhaps you have been confronted with remarks such as these. "You are not the physician your father was" or "doctors sure are not what they were in the good old days." These statements and others like these reflect changes in the image of the physician. Are these changes necessarily bad? Let us examine some of the philosophies involved.

Medicine like any other art or science has changed. This has been necessary to keep pace with our changing society. Patient load per doctor has increased. Newer diagnostic procedures and treatment measures have been introduced which require employment of the multi-personnel health team. Some of the intimate soul searching contact has been lost, but yet in its place has been substituted improved diagnostic and therapeutic materials and techniques entirely for the benefit of the patient.

Some change, therefore, in the manner in which the physician processes his patient was required. Confidence in the doctor remains absolutely essential to any successful diagnostic or therapeutic plan. This confidence, however, must sometimes be built up by modern, streamlined, personal contacts, and not by physicians sitting long hours by the bedside of the sick observing the battle of disease. Thus, the image of the physician has changed. This has been an inevitable product of our general society's growth and change, but the sincere interest of the physician in the patient remains the same as in the "good old days."

Examination of this treatise still further brings out several additional points. The public has more knowledge of disease and medical care than people did 50 years ago. This knowledge often times becomes an obnoxious element when the patient tells the doctor what he feels his care program should contain, or how it should be done. Also, people holding various insurance coverage plans often express strong sentiment as to what type of facility should be utilized in their health care. It is recognized that factors such as financial levels and insurance coverage should be well explained by the patient to his physician so that the best medical care at the lowest possible cost can be given, but the manner in which lay opinion is often expressed can frequently be criticized. The awareness of compensation and litigation processes by the patient, particularly in occupational cases, frequently presents a difficult problem in patient-physician relations.

The doctor, like the patient, has an equally important obligation to fulfill in the matter of patient–physician relationship and medical public relations. Perhaps at times the attitude of the physician may be stuffy and brusque. The nature of the patient's illness and the contemplated plan of diagnosis and treatment are often inadequately explained. Remember too if you will doctor, the patient's family and often the employer have an interest in the medical picture, and pertinent aspects of this should be included into the general explanatory program as the case develops.

Fees should be given full discussion and consideration. Realize, of course, that the education of a physician is a long and expensive process. Reward can be expected and is almost always at hand. Financial reward, however, should not be achieved at the expense of someone much less fortunate, and to the detriment of good public relations.

I feel that we as physicians expect more from the community in terms of reverence, respect and admiration, than do members of many other occupations and professions. To expect this, I feel, can be justified; however, to be justified it must be earned and deserved. Medical men as individuals and as participants in the organized medical picture must realize that they have broad responsibilities for health care. They must be ready and equipped to offer suggestions to the patients and organizations as to how medical care can best be obtained.

Yes, medicine is at the crossroads, but I am confident we have not lost our way and that the "right turn" will be made to perpetuate the image of the physician that we all hold dear, and to continue the standard of medical practice in America that has brought to this country the highest level of health care in the world.—JOHN ALLEN, M. D.

Section on Medical History Plans Important Year

SECTION ON MEDICAL HISTORY

STARTING the new year with 103 members, the Section on Medical History can look backward at the accomplishments of 1960, and foresee a year of activity which will be even more significant in presenting the history of medicine to the public.

New acquisitions continue to add to the store of historic memorabilia which furnishes material for proposed exhibits at the Charitable, Educational and Scientific Foundation's Museum of Medical Progress at Prairie du Chien, special collections of the State Historical Society and for local historical purposes. The activities of the Section on Medical History have added considerably to these collections.

Among the most recent is a donation of Beaumont material from the collection of the late Dr. Arno Luckhardt, Chicago, which was presented to the Foundation by Mrs. Luckhardt.

Doctor Luckhardt was an authority on Dr. William Beaumont, and much of the material consists of correspondence with the descendants of the pioneer physician and considerable material on the doctor and his work.

Another recent donation comes from Dr. Hamilton A. Bolstad, De Soto, consisting of 18 medical texts dating back as far as 1833. Fifteen of the books have pre-Civil War publication dates and comprise a valuable addition to the collection.

In the category of more recent medical progress is an exhibit donated by Baxter Laboratories dealing with the drug, urea, which was developed by the Wisconsin Alumni Research Foundation. Components of the exhibit are being considered for possible use in the Museum of Medical Progress.

Meanwhile, work is progressing on revisions of the present display at the Museum of Medical Progress in preparation for the season's opening April 30, 1961.

Following is the current list of members of the Section on Medical History:

SECTION ON MEDICAL HISTORY MEMBERS

Physicians:

R. N. Allin, M.D., Madison
C. E. Baumle, M.D., Monroe
S. R. Beatty, M.D., Neenah
N. O. Becker, M.D., Fond du Lac
Robert F. Boock, M.D., Beaver Dam
K. K. Borsack, M.D., Fond du Lac
R. C. Cantwell, M.D., Shawano
W. T. Casper, M.D., Milwaukee
David A. Cohen, M.D., Edgerton
Elizabeth Comstock, M.D., Arcadia
F. Gregory Connell, M.D., Oshkosh
Garrett A. Cooper, M.D., Madison
R. S. Cron, M.D., Milwaukee
James C. Curry, M.D., Appleton
G. S. Custer, M.D., Marshfield
F. A. Davis, M.D., Madison
C. W. Eberbach, M.D., Milwaukee
Norbert Enzer, M.D., Milwaukee
S. M. Evans, M.D., Milwaukee
Victor S. Falk, Jr., M.D., Edgerton
Milton Finn, M.D., Superior
Harry R. Foerster, M.D., Milwaukee
G. E. Forkin, M.D., Menasha
J. C. Fox, M.D., La Crosse
Frederick H. Goetsch, M.D., Spooner
J. E. Habbe, M.D., Milwaukee
W. P. Hamilton, M.D., Dodgeville
Arthur C. Hansen, M.D., Milwaukee
O. H. Hanson, M.D., Fort Atkinson
S. B. Harper, M.D., Madison
C. B. Hatleberg, M.D., Chippewa Falls
Eugene C. Heifetz, M.D., Milwaukee
S. L. Henke, M.D., Eau Claire
C. W. Henney, M.D., Portage
J. S. Hess, Jr., M.D., Mauston
N. A. Hill, M.D., Madison
R. S. Irwin, M.D., Milwaukee
J. Howard Johnson, M.D., Milwaukee
J. Martin Johnson, M.D., Ripon
H. E. Kasten, M.D., Beloit
J. M. King, M.D., Milwaukee

K. E. Lemmer, M.D., Madison
R. M. Lotz, M.D., Eau Claire
F. W. Madison, M.D., Milwaukee
Arthur J. McCarey, M.D., Green Bay
D. W. McCormick, M.D., Fond du Lac
H. J. McGinnis, M.D., Union Grove
William S. Middleton, M.D., Washington, D. C.
C. F. Midelfort, M.D., La Crosse
Dwain E. Mings, M.D., Monroe
S. A. Morton, M.D., Milwaukee
E. J. Netzow, M.D., Lake Mills
E. J. Nordby, M.D., Madison
C. A. Olson, M.D., Baldwin
E. H. Pawsat, M.D., Fond du Lac
Russell S. Pelton, M.D., Ripon
E. L. Perry, M.D., La Crosse
L. R. Pfeiffer, M.D., Nekoosa
D. M. Pick, M.D., Manitowoc
L. M. Pippin, M.D., Richland Center
H. W. Pohle, M.D., Milwaukee
K. L. Puestow, M.D., Madison
Sverre Quisling, M.D., Madison
N. G. Rasmussen, M.D., Dodgeville
Hans H. Reese, M.D., Madison
Edward D. Schwade, M.D., Milwaukee
A. M. Schwittay, M.D., Madison
Elvira C. Seno, M.D., Burlington
H. L. Shapiro, M.D., Prairie du Chien
L. O. Simenstad, M.D., Osceola
Lindley V. Sprague, M.D., Madison
Theodore L. Squier, M.D., Milwaukee
K. H. Stahmer, M.D., Wausau
W. D. Stovall, M.D., Madison
Edyth C. Swarthout, M.D., West Salem
Leslie Tasche, M.D., Sheboygan
A. C. Taylor, M.D., Appleton
W. A. Taylor, M.D., Portage
H. Kent Tenney, M.D., Madison
G. R. Thuerer, M.D., Rhinelander
J. E. Thompson, M.D., Nekoosa
G. O. Truex, M.D., Darien
Millard Tufts, M.D., Milwaukee
E. W. Vetter, M.D., Fond du Lac
R. L. Waffle, M.D., Fond du Lac
R. P. Welbourne, M.D., Watertown
F. L. Weston, M.D., Madison
M. L. Whalen, M.D., Bruce
F. L. Whitlark, M.D., Amery
Margaret C. Winston, M.D., Madison
D. H. Witte, M.D., Milwaukee
F. E. Zantow, M.D., Oconto

Others

Business Management Services, Inc., Stevens Point
C. H. Crownhart, Madison
Freda Meyers Nishan Foundation, Madison
Donald E. Gill, Madison
Mrs. Esther Grob (Reginald N.) Hamilton, Milwaukee
Mr. and Mrs. Frank W. Kuehl, Washington, D.C.
Robert B. Murphy, Madison
Mrs. Brand Starnes, New Lisbon
H. L. Toser, Stevens Point
Wisconsin Federation of Woman's Clubs, Stevens Point
John B. White, Madison

WATCH YOUR MAIL FOR ROUND TABLE NOTICE

SMS ANNUAL MEETING • MAY 2–3–4

About March 1 your office will receive a folder listing the Round Table Luncheons with a reservation blank included. Since registration is limited in each case, it is recommended that you file your luncheon requests immediately upon arrival of the folder. While all luncheons are open to the entire membership, on a "first-come-first-served" basis, attention is directed to the following luncheon of special interest to indicated groups:

TUESDAY, MAY 2

- ALUMNI ASSOCIATIONS
  Marquette and UW
  See page 166
- PATHOLOGISTS
  See page 166
- OB & GYN
  See page 166

WEDNESDAY, MAY 3

- INTERNISTS
  See page 167
- OB & GYN
  See page 167
- ORTHOPEDISTS
  See page 168
- PEDIATRICIANS
  See page 168
- PUBLIC HEALTH MDs
  See page 167

THURSDAY, MAY 4

- ANESTHESIOLOGISTS
  See page 169
- EENT
  See page 169
- OB & GYN
  See page 169
- RADIOLOGISTS
  See page 169
- SURGEONS
  See page 169

WATCH FOR BROCHURE ABOUT MARCH 1 AND ORDER YOUR TICKETS IMMEDIATELY

THE MEDICAL FORUM

SMS DIVISION ANNOUNCES PLAN FOR . . .

Statewide Conference On Mental Retardation

A statewide conference on "Medical Aspects of Mental Retardation," to be held in the early summer of 1961, was approved January 22 at a meeting of the Division on Nervous and Mental Diseases of the Commission on State Departments.

Supporting organizations would be the Charitable, Educational and Scientific Foundation; the medical schools; the departments of Public Instruction, Health and Public Welfare; and the associations for Mental Retardation and Mental Health.

Coordination of the conference would be by the Division on Nervous and Mental Diseases and the Commission on Scientific Medicine.

Other matters considered by the Division included hypnosis, the State Mental Health Act, county mental institutions, epilepsy and the certification of mental competency to drive an automobile.

Hypnosis

The Division also discussed the nonmedical as well as the medical use of hypnosis, with the following results:

1. The conclusion that Wisconsin's Medical Practice Act and Basic Science Law appear adequate to deal with illegal use of hypnosis in the treatment of the sick.
2. A request to the Commission on State Departments that communication with the deans of the two medical schools urge the establishment of more adequate training programs in hypnosis.
3. A request that material be prepared on hypnosis for the

(Continued on next page)

A NEW CHARTER for the Ozaukee County Medical Society was presented by Dr. E. D. Sorenson, Elkhorn, president of the State Medical Society, in January. Left to right, at the presentation, are Dr. Donald Ruch, Milwaukee; Dr. O. W. Hurth, Cedarburg; Dr. R. H. Dorr, Belgium, president of the county society; Dr. P. B. Blanchard, Cedarburg, Councilor; and Doctor Sorenson.

SMS School Health Tapes Are "Big Hit" With State Teachers

A series of 10 tape recordings on health subjects are now being offered to high school instructors on a loan basis by the State Medical Society.

Brochures describing the recordings were mailed to all school principals in the state in January for distribution to interested teachers.

In the first week following the mailing, 179 tapes were booked for future class use, and the flood of requests continues.

The tapes cover the following topics: physical fitness, emotional fitness, the heart—how it works, heart murmurs, first aid, cancer, respiratory infections, overweight, acne, and medical facts and fallacies.

Each recording is about 15 minutes in length. They were originally broadcast on the State Medical Society's "March of Medicine" radio program and have been adapted for use in high school classes.

The recordings feature Dr. H. Kent Tenney, Madison, who is director of the "March of Medicine." All have been recorded since Doctor Tenney assumed direction of the program in May, 1960, and contain up-to-date discussions of the 10 health topics.

Nervous And Mental Diseases Committee Actions Are Listed

(Continued from page 157)

postgraduate programs of the society and for the *Wisconsin Medical Journal.*

Mental Health Act

Dr. H. Kent Tenney, Madison, chairman of the State Mental Health Advisory Committee, and Harry Spindler, Madison, executive secretary of the committee, met with the Division to explain a planned review of the State Mental Health Act and all related matters in the Wisconsin Statutes. This will be done through a series of subcommittees dealing with individual sections.

The Division took the following actions:

1. Endorsed the proposal and offered to use its Subcommittee on Commitment Laws in an advisory capacity to Doctor Tenney's committee, if he should so desire.
2. Recommended that its proposals concerning review of commitment laws relating to inebriates and drug addicts be transmitted to Doctor Tenney's committee for inclusion in the over-all review.

The Division reviewed a report from its Subcommittee on Commitment Laws and recommended that it continue its meetings with the Medical-Legal Committee of the Wisconsin Psychiatric Association.

County Institutions

In response to a letter seeking suggestions for improving the psychiatric care in county mental institutions, the Division expressed the opinion that it is highly important to inform county board members, trustees, hospital administrators and social workers of the opportunities for making general progress with the care and possible release of some of the patients. The Division also felt it important to give general practitioners a further understanding of psychiatric aspects of care in the institutions.

Recommendations of the Division were:

1. **That the State Department of Public Welfare, through the Department of Mental Hygiene, bring together physicians, county board members, trustees and hospital administrators and social workers for two or three meetings each year involving didactic and clinical discussions of the care of the patients in county mental hospitals.**
2. **Encouragement should be given to those county mental hospitals which are interested in providing acute care for the mentally ill.**

Green Bay Press–Gazette Photo

A MATERNAL MORTALITY INSTITUTE, the thirteenth such program presented by the Maternal Mortality Study Committee of the State Medical Society and the State Board of Health since 1958, was held at St. Vincent's Hospital in Green Bay January 19. Attending were 62 physicians and 70 hospital representatives. Left to right, seated, are Dr. Emmet R. Killeen, Green Bay, president of the Northeastern Chapter, Wisconsin Academy of General Practice; Dr. T. A. Leonard, Madison, chairman of the Maternal Mortality Study Committee; Dr. Samuel G. Perlson, Milwaukee; Dr. Ben Peckham, Madison, member of the committee. Standing are Dr. George G. Rowe, associate professor of medicine, University of Wisconsin Medical School; and Dr. William Kreul, Racine, committee member.

Capitol Comments

With the present legislative session still in its infancy, most of the measures concerning health and medicine are still in the "expected" stage.

Of the bills thus far introduced, the Public Policy Committee of the State Medical Society has expressed support of two: Bills 2,S. and 3,S. relating to local public heatlh organization. Both bills are explained in the January, 1961, Forum.

In supporting the two bills, the Committee pointed out that the State Medical Society has supported the development of full-time adequately staffed county, city-county, and multiple county health departments since 1946.

Bill 2,S. is an effort to reduce the number of local health officers (now some 1,700) to improve the operating efficiency of the State Board of Health. Combining their functions in a county health commission will make it possible for local health organizations to better cope with new problems in public health, the Committee stated.

Bill 3,S. removes a current obstacle to the development of county, city-county or multiple county health departments—a provision which prohibits levying any cost of a county health department against the property of a village or city which maintains a full-time health department.

LET YOUR LEGISLATORS KNOW YOUR VIEWS

Following are correct addresses:

U.S. CONGRESSMEN
House Office Building
Washington 25, D.C.

U.S. SENATORS
Senate Office Building
Washington 25, D.C.

STATE LEGISLATORS
State Capitol
Madison 2, Wisconsin

Cancer Coordinating Committee Reactivated

Representatives of Wisconsin organizations interested in cancer met at the State Medical Society building in Madison January 28 to reactivate the state Cancer Coordinating Committee.

In outlining its purpose and function, the committee agreed on the following procedures:

1. Review the cancer programs of all participating organizations to observe the over-all intent and effect of these programs and make policy suggestions concerning greater coordination of all activities.
2. Improve liaison between the two cancer divisions in the state, the medical schools, state agencies interested in cancer detection and control, the State Medical Society and general practice and specialties concerned with cancer.
3. Prevent unnecessary duplication and overlapping in any of the programs undertaken by the participating groups.
4. Suggest and advise the participating groups so as to bring "action" into their programs.
5. Improve communications between all groups in Wisconsin interested in cancer.
6. Serve as a study group and research group for major problems in cancer detection and control.

It was agreed that the Cancer Coordinating Committee would be advisory in nature, and would not carry out specific projects except through the participating agencies.

Present were representatives of the State Medical Society, Wisconsin and Milwaukee divisions of the American Cancer Society, State Board of Health, the specialty organizations for surgery, pathology and internal medicine, University of Wisconsin and Marquette University, Academy of General Practice and Wisconsin Dental Society. Representatives of the obstetrics and gynecology and radiological societies also serve on the committee.

The next meeting of the coordinating committee is planned for late May, 1961. Each participating organization is to prepare a brief summary of its program activities in written form prior to the meeting, and each will discuss its policies and programs briefly before the group.

This will establish a basis for review and coordination of over-all cancer programs.

Other topics up for future consideration are control of cancer quackery, promotion of tumor registries and cytology programs, and professional and public educational programs in cancer.

Doctor Simonson Is Delegate To Meet On Children & Youth

A program-planning meeting for the Governor's Conference on Children and Youth was held in Madison in January.

The conference will be held April 7 and 8, with Dr. L. M. Simonson, Sheboygan, representing the State Medical Society. Doctor Simonson is chairman of the Division on School Health of the Commission on State Departments.

Following the pattern of the last White House Conference on Children and Youth, the state gathering will hold discussion in seven areas:

1. Guidance and counseling at all school levels.
2. Expansion of vocational training and opportunities.
3. Services to families.
4. Expansion of mental health services.
5. Human rights, responsibilities and values.
6. Moral standards of youth and adults.
7. Recreation in village and rural areas.

Following the opening session, forums and workshops will be held on each of the seven topics with a summary and closing session the following day.

Dr. H. Kent Tenney, Madison, is chairman of the Governor's Committee on Children and Youth which conducts the conference.

ON THE HORIZON

Mar. 9—Community Problems on Alcoholism, Wausau.

Mar. 9–10—Midwest Civil Defense Conference, Madison.

Apr. 7–8—Governor's Conference on Children and Youth, Madison.

Apr. 30—Museum of Medical Progress opening, Prairie du Chien.

May 19—University of Wisconsin Medical School Alumni Day, Madison.

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WHAT IS PHYSICIAN'S LEGAL POSITION IN . . .

Taking Blood Samples In Drunk Driving Cases

What is the physician's legal position regarding liability in drawing blood in cases of driving while under the influence of alcohol?

A recent communication from George E. Hall, director, Legal and Socio-Economic Division of the American Medical Association's Department of Legal Medicine states:

"The physician, like all other good citizens, is under the obligation to cooperate with law enforcement officials whenever possible, and we urge that he do so. There are, however, limitations on the extent of cooperation that is given.

"We feel that when a police officer requests a physician to draw a blood sample for chemical testing purposes, his request is a good defense to the physician only when the police officer himself is authorized by law to perform, or request the performance of, the act. [Editor's Note: In Wisconsin the police officer is not so authorized; the state does not have an implied consent law.]

"If the police officer oversteps his authority, therefore, the physician might be likely to be sued for damages for an assault and battery.

"Generally speaking, if the victim is conscious, the physician should not remove blood without his express consent. If the victim is unconscious, it would seem as a practical matter, that the police officer should be willing to make his request in writing and that the writing should state:

1. That the person has consented or is unconscious.
2. If the person is unconscious, that he is either under arrest or that sufficient grounds exist for placing him under arrest.
3. That the police officer believes that he has authority to make the request and the reasons for his so believing.

"A recent decision of the Supreme Court of the United States indicates that an unconscious person will be assumed to have consented to have the results of a blood test turned over to the police on the theory that he would consent to any test which might be to his benefit. Sometimes it is best to play safe, however, and this would seem to be one of those times.

"The question has been raised by others as to whether or not one suspected of being intoxicated can give a valid consent to a blood withdrawal when it subsequently develops upon examination of the blood sample that the individual was in fact drunk. It has been suggested that the individual's consent would then have been invalid and the physician would then have been guilty of an assault.

"Technically this is probably correct, but it should be pointed out that such a suit would be quite improbable. In order to sustain it, the individual would have to show that he was intoxicated and that would lay him open to the very serious charge of driving while intoxicated. I doubt that anyone would care to convict himself to that extent in return for the small damages which he could prove from the assault and battery."

Groups To Support Proposed Legislation On Public Health

Representatives of a dozen Wisconsin Organizations met with the Board of the Wisconsin Public Health Council to review pending legislation on local health organization January 25 at the State Medical Society building in Madison.

Main purpose was to examine bills 2,S. and 3,S. (See The Medical Forum, January, 1961) which are now before the legislature.

West Bend News Photo

WASHINGTON COUNTY MEDICAL SOCIETY and the Wisconsin Heart Association sponsored a rheumatic fever and congenital heart disease clinic in West Bend. Above Dr. John H. Huston, director of the cardiovascular research section at Marquette University School of Medicine, examines seven-year-old Gene Purtell of Rt. 1, Hartford. Twenty-five patients were examined by Doctor Huston and Dr. Richard L. Myers, Green Bay.

Dr. C. N. Neupert, State Health Officer, outlined five principles of improved local health organization which his department feels are important to Wisconsin.

1. Reduction of the number of local health officers from about 1,700 to something near 500 as a means of improving efficiency.
2. Expansion of county health nursing program by increasing state aid.
3. Revision of the County, City-County and Multiple County Health Departments Enabling Act to permit counties and municipalities to share the costs of such departments on any basis mutually agreeable to each.
4. State aid to stimulate the establishment of full time county, city-county or multiple county health departments.
5. Creation of an advisory committee on local public health to the State Board of Health.

It was agreed by all present that bills 2,S. and 3,S. should receive unequivocal support and the organizations represented would assist in encouraging their passage.

THE STATE BOARD OF MEDICAL EXAMINERS is pictured above. Left to right, seated, are William C. Henske, M.D., Chippewa Falls; Millard Tufts, M.D., Milwaukee, president; T. W. Tormey, Jr., M.D., Madison, secretary; and C. A. Olson, M.D., Baldwin. Standing, left to right, are Gunnar A. Gundersen, Jr., M.D., La Crosse; H. G. Withrow, D.O., Hustisford; Irvin L. Slotnik, M.D., Milwaukee; and Thomas E. Henney, M.D., Portage.

Start Rehabilitation Programs In Various Sections Of State

A positive program for aging is not just a well worded statement for physicians and health personnel in many parts of Wisconsin. Evidence of this is contained in a report of Dr. G. M. Shinners, district health officer at Green Bay.

An indication of the type of programs being carried on to a greater or lesser degree in various areas of the state is given in a review of the Marinette County Rehabilitation Program.

Starting with a planning meeting on June 8, 1960, physicians and other health care personnel in the area have made significant advances in coordinating existing community resources into an effective rehabilitation program.

Engaged in the initial discussions were Dr. C. H. Boren, Marinette, Dwayne Hall, administrator of the Marinette General Hospital, and a physical therapy consultant of the State Board of Health.

They were soon joined by representatives from the hospital staff, the nursing homes and public health nursing services in the city and county.

The physical therapy consultant began visiting the hospital and nursing homes on a regular schedule to provide demonstration services to those patients whose physicians approved and supervised care. This was later extended into the homes of certain patients.

In all, 31 patients have been formally admitted to service.

During this clinical phase of the program, the planning group developed a patient referral form to be sent with the patient from the hospital to the nursing home to the patient's home via the public health nurse to facilitate continuity of patient care.

On September 28 the didactic phase of the in-service program started with meetings at Marinette General Hospital. These presentations have covered rehabilitative principles involving strokes, hip fracture, arthritis, neurology, and amputation. Live patient demonstrations have been used in most sessions to show positioning, passive and active exercises, transfer from bed to chair, resistive exercises, ambulation, and activities of daily living.

"The group is convinced that their experience over the past several months has been worthwhile and an excellent opportunity for the various community services to get together and learn," according to Doctor Shinners.

A similar program got underway in the Manitowoc area on July 7, with Dr. R. M. Strong, Manitowoc, participating in the planning and presentation. Mrs. Janet Born, director of nurses at Manitowoc Memorial Hospital, served as chairman.

Twenty-four patients were formally admitted to the program through physician referral and additional patients have been seen incidentally.

The Door-Kewaunee area launched its program on November 9, with Dr. Patricia Lanier, Kewaunee, as medical advisor. Leonard Ferris, administrator of the Algoma Hospital is chairman, and Estelle Fidler, R.N., Sturgeon Bay city nurse, is secretary.

Their formal program will begin March 1. Twelve monthly meetings of two hours each are being planned based on rehabilitative principles involving strokes, hip fractures, arthritis, amputations, diabetes, neurological diseases and spinal cord injuries. There will be discussions, demonstrations, case presentations and practice sessions.

Three hospitals, city and county public health nurses and five nursing homes are among the participants in the program.

Perhaps the number of individuals helped thus far, 31 in the Marinette area and 24 in the Manitowoc area, may not seem too impressive at first glance. However, considering the other localities in which such services are developing and the framework that has now been established, the benefit becomes a significant and growing factor in the care of Wisconsin's aged citizens, helping them to help themselves and making maximum use of existing facilities.

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White House Conference On Aging Results In A Large Number Of Recommendations

"Aging Parley Win Seen for Social Security Side." This was how the *Washington Post* saw the White House Conference on Aging, held January 9–12.

And this is undoubtedly the impression the general public retains from the conference, in which 2,475 delegates covered 20 specific subject areas on the problems of the aged.

In effect it was a "win" for the "social security side." Although only 14 of the 34 states which recommended specific financing methods to the conference favored a social security method approach, a vote of 170 to 99 in the Section on Financing Medical Care resulted in the following statement:

"Private voluntary effort and public assistance can contribute much to the solution of the problem of health care for the aged. However, they will continue to fall short of meeting the basic medical care needs of the aged as a whole. The majority of the delegates of the Section on Financing Medical Care believe that the social security mechanism should be the basic means of financing health care for the aged."

The Section on Health and Medical Care voted 196 to 66 that "health care under the social security mechanism is unnecessary and undesirable," and that individual and voluntary efforts plus public assistance and the Kerr-Mills bill will provide "effective, economical, dignified medical care for our elderly citizens."

However, the conference chairman ordered the action stricken.

And the record stands—for Social Security medical care.

For the most part, the actions of the other 19 sections at the White House Conference were overlooked in the concentration on how to finance medical care for the aged.

It required 25,000 words just to summarize the recommendations which came out of the sections. In brief, here are some of the recommendations:

Racine Journal–Times Photo

LABOR'S VIEWS on workable voluntary health insurance programs were heard in a November meeting by members of the Racine County Medical Society. Left to right, pictured at the meeting, are: Dr. William Bennett, president of the county society; Sam Rizzo, Racine, international representative for the United Auto Workers; and UAW representative James Brindle, Detroit, who gave the presentation.

1. OASDI should be extended to all who work.
2. Social Security retirement benefits should adjust upward (or downward) with changes in prices and wages.
3. Self-employed persons should be permitted to obtain tax-free coverage comparable to that available for those under private pension and deferred profit sharing plans.
4. Earnings limits on Social Security retirees should be raised.
5. Women should be eligible for Old Age Assistance at age 62 instead of 65.
6. Compulsory retirement at 65 should be eliminated, and anti-age discrimination legislation should be enacted.
7. Wage base for computing OASDI taxes should be increased from $4,800 to some higher figure.
8. Greatly expanded public housing, plus private building, should be undertaken especially for the aged.
9. Local community councils on aged should be established nationwide.
10. Permanent, independent departments of aging should be set up in each state.
11. Some form of Federal coordinating agency on aging should be set up.
12. Every governmental program of health care for the aged should embody a provision granting beneficiaries full freedom in choosing a physician, dentist, hospital, nursing home, dispenser of prescription medications, or other providers of health services.
13. Special emphasis is needed to develop programs of care at home for older persons, locally operated and controlled.
14. Mental health needs of older people should be given greater attention in over-all mental health programs.
15. Rehabilitation services could well be a condition of accreditation

(Continued on next page)

Kenosha Health Worker Is "Woman Of The Year"

Mrs. Cecil D. Snyder, director of volunteers at the Kenosha Hospital, has been selected as the 1960 Kenosha "Woman of the Year." The daughter and granddaughter of physicians, she was honored for her dedication to aiding the sick.

A letter of congratulations from the State Medical Society contained a series of postage stamps honoring Dr. Albert Schweitzer, in whose career Mrs. Snyder has been actively interested.

THE NATIONAL CONFERENCE ON PHYSICIANS AND SCHOOLS is under discussion by, left to right, Dr. T. W. Tormey, Jr., Madison. Dr. L. M. Simonson, Sheboygan; and Dr. H. W. Carey, Lancaster. The meeting is scheduled in Chicago on March 9, 10 and 11 at the Sheraton Towers Hotel, under sponsorship of the American Medical Association.

White House Aging Conference

(Continued from page 162)

for hospitals, particularly those with approved internship training programs.

16. Private enterprise, voluntary organizations and government at all levels must "make available" funds necessary to finance facilities and assistance to trainees so that the supply of professional personnel can be advanced.

Comparing Wisconsin's report to the White House Conference with those of other states, Dr. Adolph M. Hutter, Fond du Lac, one of the state's 48 delegates, said, "We have much to be proud of."

"The aged in Wisconsin have an amazing variety of active and helpful voluntary organizations to assist them, when they want it. We have made outstanding progress in mental health, hospital and nursing home care, homes for the aged, rehabilitation, and many other services for the aged."

Doctor Hutter, who is chairman of the State Medical Society's Division on Aging of the Commission on State Departments, called on the governor and legislature to act promptly to take full advantage of new Federal legislation providing medical assistance to the aged.

In addition he urged voluntary and state agencies to call a joint conference on how home care services can be encouraged in Wisconsin. He mentioned such specifics as homemaker and housekeeping services, "meals on wheels," and practical nursing services to aged persons who may need them on a full or part-time basis.

Dr. Patricia Lanier, Kewaunee, another Wisconsin delegate, called the conference "provocative, stimulating, and controversial."

She objected to the fact that the final reports were merely read to the delegates, with no opportunity to discuss, pass judgment on, or add to them.

"If the most controversial subject, as it appeared, concerned the medical care of the aged, then all attending the conference ought to have had some opportunity to discuss it, regardless of what the outcome might be," she added.

"I was particularly disturbed that almost all of the recommendations from the 20 different sections asked for Federal funds for the development of this or that service for the aged," said Doctor Lanier.

The section in which she participated, Social Services, emphasized that the local communities should be the leaders in providing necessary social services, but these communities must have trained leadership. "I do feel that physicians, as such, in all areas should become more conversant with the various social services that are available . . .," she said.

"I believe it is very important that all medical societies, whether they be large or small, become conversant with these various outcomes of the White House Conference," Doctor Lanier concluded.

MEDICAL PLAN DESERVES TEST

Stating that an early attempt will be made by Congress to push through legislation providing medical benefits for older persons on social security, *The Milwaukee Journal*, in an editorial on January 3 stated in part:

"The charge will be heard that the compromise bill passed by the last Congress, under which the Federal government will help states provide medical care for the needy aged, 'isn't doing the job'.

"There are weaknesses in the new program. But there are virtues, too. Great advances are being made from many directions—health insurance, pension and welfare programs, for example—changing the situation and needs of older persons, so far as medical care financing is concerned. So there is merit in the idea of adjusting medical care benefits to individual needs rather than giving limited benefits to everyone on Social Security, regardless of individual circumstances.

"If the hastily drawn legislation passed in the closing days of the last Congress isn't doing the job as adequately or fast as should be, there is no reason why it can't be improved."

Medical-Press Dinner Held By Dane County Society

The annual Medical-Press dinner of the Dane County Medical Society was held February 22.

During the evening the annual Dane County Press Award was presented to Jerry Deane of station WISC–TV, Madison, for outstanding reporting of a medical news story.

Milwaukee Man Named To Nursing Home Committee

The State Board of Health has appointed Curtis B. Gallenbeck, Milwaukee, to fill an unexpired term on its advisory committee on nursing homes. Mr. Gallenbeck, personnel manager of Inland Steel Products Co., succeeds Robert B. Murphy, Madison.

SPECIAL WJPG BROADCAST

Saturday 8:45 A.M.

MARCH OF MEDICINE

Programs of The State
Medical Society of Wisconsin

This Week's Topic, Narrated by

Dr. H. Kent Tenney

"HYPERTENSION"

(High Blood Pressure)

March of Medicine Programs Will be a
Regular 8:45 A.M. Feature of WJPG

This Message Sponsored By

Doctors of Brown County
Medical Society

As A Public Service

A PUBLIC RELATIONS CAMPAIGN of the Brown County Medical Society of which the above advertisement is an example involves placement in the local newspaper of advertisements supporting such things as the Kerr-Mills approach to medical care for the aged, the March of Medicine radio program which started recently over Station WJPG in Green Bay, and the free enterprise system.

WIAA Adopts Dental Guards

Dental guards will become part of the standard equipment of high school football players in Wisconsin beginning with the 1962 season.

"While dental guards have been and still are a controversial item, there is no question that some type of protection is necessary to combat injuries involving teeth as well as concussions," said the January WIAA bulletin.

Records of the Wisconsin Interscholastic Athletic Association's Accident Benefit Plan show that approximately 10 per cent of all paid claims deal with dental injuries.

Polio Program Reaffirmed By Dane Medical Society

The Board of Trustees of the Dane County Medical Society has reaffirmed its plan for immunization of all residents in the community against polio. Salk vaccine will be used since oral vaccine is presently unavailable.

Charges in the program are as follows:

1. At the regular rate charged by one's own physician.
2. If one cannot afford this, immunization will be given at $1.00 per dose.
3. If this cannot be afforded, immunization will be given at no cost to the patient, as the Dane County Medical Society underwrites the cost of the vaccine.

DATE TO REMEMBER

The second annual County Medical Society Presidents and Secretaries Conference will be held at the State Medical Society building in Madison on March 22.

Doctor Draft May Be Near

The Armed Forces have been giving indications that a physician draft may become necessary in the near future. Reason: not enough graduating physicians are volunteering or going into reserve programs.

As a result, Wisconsin Selective Service is screening 1-A physicians born in 1932 and later. It has asked the Medical Advisory Committee of the State Medical Society, headed by Dr. F. L. Weston, Madison, to provide recommendations on their availability.

Set Welfare Committees

The Wisconsin Legislature has announced appointments to the Senate and Assembly Public Welfare Committees, which will handle most of the bills affecting health and medicine. They are:

Assembly Public Welfare Committee

Walter E. Terry, Baraboo, Chmn.
Robert I. Johnson, Mondovi
Harvey L. Dueholm, Luck
D. Russell Wartinbee, La Crosse
Norbert Nuttelman, West Salem
Mark W. Ryan, Milwaukee
Isaac N. Coggs, Milwaukee
Ervin Mueller, Milwaukee
Marvin Babbitt, Seymour
Elmer J. Schowalter, Jackson
Harvey Gee, Wisconsin Rapids

Senate Public Welfare Committee

Raymond C. Bice, La Crosse, Chmn.
Peter P. Carr, Janesville
Ernest C. Keppler, Sheboygan
William R. Moser, Milwaukee
James B. Brennan, Milwaukee

MILWAUKEE AUDITORIUM

Preliminary Program—Annual Meeting

STATE MEDICAL SOCIETY OF WISCONSIN

May 2-3-4, 1961 Milwaukee Auditorium and Hotel Schroeder

Tuesday—May 2

10:00 A.M.—CLINICAL CONFERENCES

I. MARQUETTE UNIVERSITY SCHOOL OF MEDICINE

PLANKINTON HALL—Milwaukee Auditorium
Moderator: John S. Hirschboeck, M.D., Dean, Milwaukee

10:00—PAIN RELIEF IN ADVANCED CANCER
Jay J. Jacoby, M.D., Milwaukee

10:15—PRESERVATION OF CELLS AND TISSUES BY FREEZE-DRYING
Donald Greiff, ScD., Milwaukee

10:30—A REVIEW OF AVAILABLE ANTITUMOR CHEMICALS FOR CLINICAL HUMAN USE
John D. Hurley, M.D., Milwaukee

10:50—THE DIAGNOSIS AND TREATMENT OF HYPERTENSION SECONDARY TO HYPERALDOSTERONISM
Larry G. Carey, M.D., Milwaukee

11:05—DIAPHRAGMATIC REPLACEMENT; SURGICAL TECHNIQUES
Wilson Weisel, M.D., Milwaukee

11:20—THE THEORETICAL BASIS AND CLINICAL APPLICATION OF THE PROTHROMBIN TIME AND PROTHROMBIN CONSUMPTION TIME
Armand J. Quick, M.D., Milwaukee

II. UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

ENGELMANN HALL—Milwaukee Auditorium
Moderator: John Z. Bowers, M.D., Dean, Madison

10:00—THE ANESTHESIOLOGIST OUTSIDE OF THE OPERATING ROOM
James H. Barbour, M.D., Madison

10:20—RHEUMATOID ARTHRITIS; PROBLEMS IN THERAPY
John Z. Bowers, M.D., Dean, Madison
John H. Flinn, M.D., Madison

10:40—RECENT PROGRESS IN MEDICAL GENETICS
Charles W. Cotterman, Ph.D., Madison

11:00—REHABILITATION OF PATIENTS WITH INJURIES OF THE SPINAL CORD
Arthur A. Siebens, M. D., Madison

11:20—CELL CULTURE; A STUDY OF NORMAL AND MALIGNANT GROWTH
Gerald Mueller, M.D., Madison

11:40—RECENT ADVANCES IN CARDIAC SURGERY
William P. Young, M.D., Madison

12:15 P.M.—NOON LUNCHEONS

MILWAUKEE AUDITORIUM

1. **MARQUETTE UNIVERSITY SCHOOL OF MEDICINE ALUMNI ASSOCIATION**

   MARKET HALL. Reservations should be made through Mr. Ray Pfau, 620 N. 14th St., Milwaukee 3. $2.50

2. **UNIVERSITY OF WISCONSIN MEDICAL SCHOOL ALUMNI ASSOCIATION**

   JUNEAU HALL. Reservations should be made through Mr. Ralph Hawley, 418 N. Randall St., Madison 6. $3.50 (Including cocktails)

   Speaker: **V. E. Suomi, Ph.D.,** Professor of Meteorology.

   Subject: **Medical Significance of Space Satellites.**

HOTEL SCHROEDER

1. **PROBLEMS IN THE HISTOLOGIC DIAGNOSIS OF THYROID CANCER**

   Robert C. Horn, Jr., M.D., Detroit, Mich.

   Moderator: Joseph Lubitz, M.D.

   EAST ROOM—5th FLOOR

2. **TREATMENT OF PRIMARY DYSMENORRHEA**

   Somers H. Sturgis, M.D., Boston, Mass.

   Moderator: Benjamin E. Urdan, M.D., Milwaukee

   ENGLISH ROOM—5th FLOOR

3. **CAN A PHYSICIAN'S CONDUCT BE MEDICALLY SCIENTIFIC, AND YET LEGALLY IN VIOLATION OF THE LAW?**

   Mr. Harry W. Ginty, Vice-president, The Medical Protective Co., Fort Wayne, Ind.

   Moderator: Elston L. Belknap, M.D., Milwaukee

   PERE MARQUETTE ROOM—5th FLOOR

2:00 P.M.—SPECIAL PROGRAMS

I. INTERNAL MEDICINE*

PLANKINTON HALL—Milwaukee Auditorium

Moderator: Helen A. Dickie, M.D., Madison

2:00—SARCOIDOSIS
Harold Israel, M.D., Philadelphia, Pa.

2:30—MANAGEMENT OF ATELECTASIS IN BRONCHIAL ASTHMA
D. B. Radner, M.D., Chicago, Ill.

3:00—Recess to View Exhibits

3:45—PLEURISY WITH EFFUSION
David T. Carr, M.D., Rochester, Minn.

4:05—PANEL ON PLEURAL DISEASE

Moderator: David T. Carr, M.D., Rochester, Minn.

Participants: **Harold Israel, M.D.,** Philadelphia, Pa.; **Donald Stevenson, M.D.,** Madison; **Helen A. Dickie, M.D.,** Madison; **D. B. Radner, M.D.,** Chicago, Ill.; **Ben R. Lawton, M.D.,** Marshfield

II. OBSTETRICS AND GYNECOLOGY

JUNEAU HALL—Milwaukee Auditorium

Moderator: David J. Werner, M.D., Milwaukee

2:00—PROPHYLAXIS IN GYNECOLOGY
Edwin J. DeCosta, M.D., Chicago, Ill.

2:30—POLYCYSTIC OVARY SYNDROME
Somers H. Sturgis, M.D., Boston, Mass.

3:00—Recess to View Exhibits

3:45—Panel on GYNECOLOGIC ENDOCRINOLOGY

Moderator: David J. Werner, M.D., Milwaukee

Participants: **Edwin J. DeCosta, M.D.,** Chicago, Ill. **Somers H. Sturgis, M.D.,** Boston, Mass.

4:30—Business Meeting of Wisconsin Society of Obstetrics and Gynecology

III. PATHOLOGY

ENGELMANN HALL—Milwaukee Auditorium

Moderator: David J. Carlson, M.D., Milwaukee

2:00—THE HISTOPATHOLOGY OF THYROID DYSFUNCTION

Robert C. Horn, Jr., M.D., Detroit, Mich.

2:30—LABORATORY DIAGNOSIS OF THYROID DISEASE

Robert J. Fink, M.D., Eau Claire

3:00—Recess to View Exhibits

3:45—DIAGNOSTIC AND THERAPEUTIC CLINIC WITH CASE PRESENTATIONS

Coordinator: David J. Carlson, M.D., Milwaukee

Special Consultant: **Robert C. Horn, Jr., M.D.,** Detroit, Mich.

IV. PSYCHIATRY

KILBOURN HALL—Milwaukee Auditorium

Moderator: Gilbert B. Tybring, M.D., Madison

2:00—SPECIAL LEGAL ASPECTS OF PSYCHIATRIC TREATMENT

Mr. Harry W. Ginty, Vice-president, The Medical Protective Co., Fort Wayne, Ind.

2:45—DISCUSSION

3:00—Recess to View Exhibits

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* *Planned in Cooperation with the Wisconsin Society of Internal Medicine and the Wisconsin Chapter of the American College of Chest Physicians.*

3:45—Panel on TRAUMATIC NEUROSIS

Moderator: Gilbert B. Tybring, M.D., Madison

Participants: **William H. Heywood, M.D.**, Marshfield; **Francis J. Millen, M.D.**, Milwaukee; **Mr. Ralph E. Gintz**, Director, Workmen's Compensation Division, Wisconsin Industrial Commisson, Madison

8:00 P.M.—FIRESIDE CONFERENCES

HOTEL SCHROEDER—TOPICS AND SPEAKERS IN MARCH JOURNAL

Wednesday—May 3

9:00 A.M.—EXHIBITS

SPECIAL LECTURE PROGRAMS

I. INTERNAL MEDICINE *(9:00 A.M.)

ENGELMANN HALL—Milwaukee Auditorium

Moderator: Ross Kory, M.D., Milwaukee

9:00—HAIRSPRAY PNEUMONITIS
R C. Buxbaum, M.D., Madison

9:15—CAVITARY PULMONARY DISEASE FOLLOWING EMBOLI
Allan Kind, M.D., Marshfield

9:30—Panel on PULMONARY EMBOLISM AND INFARCTION
Moderator: Harold Israel, M.D., Philadelphia
Participants: **D. B. Radner, M.D.**, Chicago, Ill.; **David T. Carr, M.D.**, Rochester, Minn.; **William Stead, M.D.**, Milwaukee; **James M. Sullivan, M.D.**, Milwaukee

10:15—Recess to View Exhibits

10:30—ETIOLOGY AND PATHOGENESIS OF PULMONARY EMPHYSEMA
Hollis G. Boren, M.D., Houston, Tex.

11:00—DIAGNOSIS OF LOCALIZED PULMONARY DISEASE
(An hour's discussion of case presentations: "Stump the Experts!")
Moderator: John Rankin, M.D., Madison
Participants: **Walter H. Jaeschke, M.D.**, Madison; **John R. Pellett, M.D.**, Madison; **John H. Juhl, M.D.**, Madison; **Harold Israel, M.D.**, Philadelphia, Pa.; **David T. Carr, M.D.**, Rochester, Minn.; **Hollis G. Boren, M.D.**, Houston, Tex.; **William Stead, M.D.**, Milwaukee

II. GENERAL PRACTICE (10:00 A.M.)

PLANKINTON HALL—Milwaukee Auditorium

(Program arranged in cooperation with Wisconsin Academy of General Practice, and provides 6 hours of Category I credit for A.A.G.P. members in attendance at both morning and afternoon programs.)

Moderator: Robert E. Callan, M.D., Milwaukee

10:00—RECOGNITION OF THE AEROPHAGIC SYNDROMES
J. L. A. Roth, M.D., Philadelphia, Pa.

10:30—TUMORS IN CHILDHOOD
Tague Chisholm, M.D., Minneapolis, Minn.

11:00—CANCER RESEARCH IN RUSSIA AND THE UNITED STATES
J. R. Heller, M.D., New York City
(Lecture provided by Cancer Division, Wisconsin State Board of Health)

11:30—HEAD INJURIES IN INFANCY AND CHILDHOOD
Richard C. Schneider, M.D., Detroit, Mich.

12:15 P.M.—SCIENTIFIC LUNCHEONS

HOTEL SCHROEDER

1. POST-CHOLECYSTECTOMY SYNDROME
J. L. A. Roth, M.D., Philadelphia, Pa.
Moderator: M. C. F. Lindert, M.D., Milwaukee
EAST ROOM—5th FLOOR
2. THE SURGICAL TREATMENT OF THE HYPERTROPHIC ARTHRITIC PATIENT WITH NEUROLOGICAL SIGNS AND SYMPTOMS
Richard C. Schneider, M.D., Detroit, Mich
Moderator: James E. Miller, M.D., Madison
ENGLISH ROOM—5th FLOOR
3. INTESTINAL OBSTRUCTION IN NEWBORN INFANTS
Tague Chisholm, M.D., Minneapolis, Minn.
Moderator: Marvin Glicklich, M.D., Milwaukee
ROOM 507—5th FLOOR
4. DIFFERENTIAL DIAGNOSIS OF ASTHMA IN CHILDHOOD
George B. Logan, M.D., Rochester, Minn.
Moderator: Harry R. Weil, M.D.
ROOM 508—5th FLOOR
(Business Meeting of Wis. Allergy Society members attending luncheon, at 1:45 p.m.)
5. WHAT CAN BE DONE TO REDUCE THE TOLL OF OUR SECOND CAUSE OF DEATH?
J. R. Heller, M D., New York City
Moderator: Carl N. Neupert, M.D., Madison
PARLOR A—4th FLOOR
6. ITCHING
Sture A. M. Johnson, M.D., Madison
PARLOR C—4th FLOOR
7. ANESTHETIC PROBLEMS OF THE SMALL HOSPITAL
Jay J. Jacoby, M D., Milwaukee
PARLOR D—4th FLOOR
8. INDUCTION OF LABOR
M. Edward Davis, M.D., Chicago, Ill.
Moderator: **M. Alex Krembs, M.D.**, Milwaukee
PARLOR E—4th FLOOR
9. OFFICE PROCTOLOGY
Robert T. McCarty, M.D., Milwaukee
PARLOR F—4th FLOOR

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* *Planned in Cooperation with the Wisconsin Society of Internal Medicine and the Wisconsin Chapter of the American College of Chest Physicians.*

SPECIAL LUNCHEONS (Nonscientific)

12:15—**CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION** of the State Medical Society of Wisconsin
PERE MARQUETTE ROOM—5th FLOOR—HOTEL SCHROEDER

12:00—**CLINIC MANAGERS' LUNCHEON**
8th FLOOR—MILWAUKEE ATHLETIC CLUB

2:00 P.M.—SPECIAL PROGRAMS

I. GASTROENTEROLOGY

ENGELMANN HALL—Milwaukee Auditorum
Moderator: M. C. F. Lindert, M.D., Milwaukee

2:00—**INDIVIDUALIZED SELECTION OF ULCER OPERATIONS**
J. L. A. Roth, M.D., Philadelphia, Pa.
(William Beaumont Memorial Lecture)

2:30—**PEPTIC ULCER IN CHILDREN**
Joseph Shaiken, M.D., Milwaukee

2:45—**GASTRIC ULCER—SELECTIVE CONSIDERATIONS**
Jack Levin, M.D., Milwaukee

3:00—**Recess to View Exhibits**

3:45—**DIAGNOSTIC CLINIC OF CASE STUDIES**
Moderator: Irvin M. Becker, M.D., Milwaukee
Participants: **Walton Thomas, M.D.,** Milwaukee; **Robert T. McCarty, M.D.,** Milwaukee; **Harry Kanin, M.D.,** Milwaukee; and **Philip B. O'Neill, M.D.,** Milwaukee
Note: Any physician having a case he wishes discussed, presenting an interesting diagnostic problem in gastroenterology should write Irvin M. Becker, M.D., 425 E. Wisconsin Ave., Milwaukee 2, Wisconsin

II. GENERAL PRACTICE

PLANKINTON HALL—Milwaukee Auditorium
Moderator: A. L. Stahmer, M.D., Wausau

2:00—**NEWER DEVELOPMENTS IN CHEMOTHERAPY OF SOLID TUMORS**
Fred J. Ansfield, M.D., Madison

2:30—**MENSTRUAL IRREGULARITY**
M. Edward Davis, M.D., Chicago, Ill.

3:00—**Recess to View Exhibits**

3:45—**COMPLICATIONS OF HYPERTENSION THERAPY**
Alan J. Kanter, M. D., Chicago, Ill.
(Lecture sponsored by Wallace Laboratories)

4:15—**SAVING THE "HOPELESS" BURN CASES**
Sidney K. Wynn, M.D., and **Burton A. Waisbren, M.D.,** Milwaukee

III. ORTHOPEDIC SURGERY

JUNEAU HALL—Milwaukee Auditorium
Moderator: James E. Miller, M.D., Madison

2:00—**CERVICAL SPINE INJURIES, WITH POSSIBLE TRAUMA TO THE CORD**
Richard C. Schneider, M.D., Detroit, Mich.

2:45—**DISCUSSION**

3:00—**Recess to View Exhibits**

3:45—**(See March Journal for speaker)**

4:15—**NEWER TREATMENT OF COMPRESSION FRACTURES**
George H. Vogt, M.D., Madison

IV. PEDIATRICS

KILBOURN HALL—Milwaukee Auditorium
Moderator: (To be announced later)

2:00—**THE HERNIA PROBLEM IN PEDIATRICS**
Tague Chisholm, M.D., Minneapolis, Minn.

2:30—**(Subject in Pediatric Allergy Not Yet Selected)**
George B. Logan, M.D., Rochester, Minn.

3:00—**Recess to View Exhibits**

3:45—**PEDIATRIC CLINIC**
Staff of Milwaukee Children's Hospital
(Cases in areas of pediatric surgery and pediatric allergy will be presented for discussion)

Thursday—May 4

9:00 A.M.—EXHIBITS

BRUCE HALL—Milwaukee Auditorium
Exhibits open for study of scientific and technical displays.

10:00 A.M.—GENERAL SCIENTIFIC SESSION

PLANKINTON HALL—Milwaukee Auditorium
Moderator: M. C. F. Lindert, M.D., Milwaukee

10:00—**DOES YOUR PATIENT "NEED" A PSYCHIATRIST?**
Eugene S. Turrell, M.D., Milwaukee

10:30—**EVALUATION AND MANAGEMENT OF EYE PROBLEMS COMMONLY ENCOUNTERED IN GENERAL PRACTICE**
Kenneth L. Roper, M.D., Chicago, Ill.

11:00—**THE RECOGNITION AND TREATMENT OF HEART FAILURE IN THE OPERATING ROOM**
Kenneth K. Keown, M.D., Columbia, Mo.

11:30—**FUNDAMENTALS OF ROENTGEN DIAGNOSIS OF THE ACUTE ABDOMEN**
Benjamin Felson, M.D., Cincinnati, Ohio

12:15 P.M.—SCIENTIFIC LUNCHEONS

HOTEL SCHROEDER

1. **SURGICAL ASPECTS OF ALIMENTARY TRACT CANCER**
   Owen Wangensteen, M.D., Minneapolis, Minn.
   Moderator: A. R. Curreri, M.D., Madison
   PERE MARQUETTE ROOM—5th FLOOR
2. **SPLENOPORTOGRAPHY**
   Benjamin Felson, M.D., Cincinnati, Ohio
   Moderator: F. F. Golden, M.D., Madison
   ENGLISH ROOM—5TH FLOOR
3. **ARRHYTHMIAS ASSOCIATED WITH ANESTHESIA**
   Kenneth K. Keown, M.D., Columbia, Mo.
   Moderator: George C. Kreuter, M.D., Milwaukee
   ROOM 507—5th FLOOR
4. **UTERINE BLEEDING—TOO MUCH AND TOO LITTLE**
   Ben M. Peckham, M.D., and **William Kiekhofer, M.D.,** Madison
   ROOM 508—5th FLOOR
5. **E.E.N.T. LUNCHEON**
   (No luncheon speaker, but program begins immediately following lunch. See details of program below)
   EAST ROOM—5th FLOOR
6. **MANAGEMENT OF RESISTANT CONGESTIVE HEART FAILURE**
   Francis D. Murphy, M.D., Milwaukee
   PARLOR A—4th FLOOR
7. **NOTHING ON BURNS**
   George E. Collentine, Jr., M.D., John D. Conway, M.D., and **Walter J. Woloschek, M.D.,** Milwaukee
   PARLOR C—4th FLOOR

SPECIAL LUNCHEONS (Nonscientific)

12:15—PAST PRESIDENT'S LUNCHEON
PARLOR G—4th FLOOR—Hotel Schroeder

1:00 P.M.—SPECIAL PROGRAMS

I. OPHTHALMOLOGY & OTOLARYNGOLOGY

EAST ROOM (5th floor)—Hotel Schroeder

Moderator: Clemens G. Kirchgeorg, M.D., Neenah

1:00—BUSINESS MEETING

2:00—THE CATARACT OPERATION: A STUDY OF DETAILS
Kenneth L. Roper, M.D., Chicago, Ill.

2:45—SURGERY FOR HEARING IMPAIRMENT
Jerome A. Hilger, M.D., St. Paul, Minn.

3:15—DISEASES OF THE LARYNX: DIAGNOSIS AND TREATMENT
Charles J. Finn, M.D., Milwaukee

2:00 P.M.—SPECIAL PROGRAMS

I. ANESTHESIOLOGY

ENGELMANN HALL—Milwaukee Auditorium

Modeator: George C. Kreuter, M.D., Milwaukee

2:00—PULMONARY HYPERTENSION
Frederick Van Bergen, M.D., Minneapolis, Minn.

2:30—ANESTHESIA FOR INTRACARDIAC SURGERY
Kenneth K. Keown, M.D., Columbia, Mo.

3:00—Recess to View Exhibits

3:45—ALTERED BLOOD VOLUME IN SURGICALLY CONTRACTABLE HEART DISEASE
Robert A. Schmidt, M.D., Milwaukee

4:15—PULMONARY FUNCTION STUDIES AFTER OPEN HEART SURGERY
Carl W. Schmidt, M.D., and **Karl Siebecker, M.D.,** Madison

4:30—A REVIEW OF THE CURRENT STATUS OF CARDIAC RESUSCITATION
Kenneth C. Leenhouts, M.D., Waukesha

II. RADIOLOGY

WALKER HALL—Milwaukee Auditorium

Moderator: F. F. Golden, M.D., Madison

2:00—FILM-READING SESSION AS A TEACHING TECHNIQUE
Benjamin Felson, M.D., Cincinnati, Ohio

2:30—ENDOCARDIAL FIBROELASTOSIS
Donald P. Babbitt, M.D., Milwaukee

2:45—AIR CONTRAST STUDY OF THE COLON
Theodore Glaessner, M.D., Milwaukee

3:00—Recess to View Exhibits

3:45—ROENTGENOLOGIC CONTRIBUTIONS IN THE STUDY OF RENAL HYPERTENSION
George D. Davis, M.D., Rochester, Minn.

4:15—A NEW DOSIMETER
John Cameron, Ph.D., Madison

4:30—BUSINESS SESSION
Section on Radiology

4:45—BUSINESS SESSION
Executive Committee, Wisconsin Radiological Society

7:00—DINNER, Wisconsin Radiological Society
Members Only, University Club (Reservations through Robert Byrne, Columbia Hospital, Milwaukee 11)
Speaker: **George D. Davis, M.D.,** Rochester, Minn.
Subject: **POSTBULBAR DUODENAL ULCER**

III. SURGERY

PLANKINTON HALL—Milwaukee Auditorium

Moderator: Peter Midelfart, M.D., Eau Claire

2:00—GASTROINTESTINAL INTUBATION
Owen Wangensteen, M.D., Minneapolis, Minn.
(Erastus B. Wolcott Memorial Lecture)

(Balance of program being arranged by Wisconsin Surgical Society and details available at a later date)

Marquette University School of Medicine

in cooperation with the Milwaukee County Hospital

PRESENTS A POSTGRADUATE COURSE

on

CURRENT PROBLEMS IN INTERNAL MEDICINE

TIME Thursday Mornings, 9 to 12; March 2, 9, 16, and 23, 1961

PLACE Milwaukee County Hospital, Fifth Floor Conference Room

DIRECTOR Joseph W. Rastetter, M.D., Associate Professor of Medicine, Marquette University School of Medicine

PROGRAM

1st Session: March 2, 1961

9:00 A.M. Management of Bronchial Asthma—John A. Arkins, M.D.
9:30 A.M. Office and Bedside Evaluation of Pulmonary Function—Wm. W. Stead, M.D.
10:00 A.M. Therapy with the Newer Antibiotics Including the Synthetic Penicillins Burton A. Waisbren, M.D.
10:30 A.M. Fungus Diseases Seen in Wisconsin: Diagnosis and Management. Burton A. Waisbren, M.D.
11:00 A.M. Office Problems Involving Heart Murmurs—John H. Huston, M.D.
11:30 A.M. Indications for Cardiac Catheterization—John H. Huston, M.D.

2nd Session: March 9, 1961

9:00 A.M. Management of the Obese Patient—Willard A. Krehl, Ph.D., M.D.
9:30 A.M. Management of Pulmonary Emphysema—Wm. W. Stead, M.D.
10:30 A.M. Problem of Goiter—Norman H. Engbring, M.D.
11:30 A.M. Pancreatitis: Diagnosis and Treatment—Jack J. Levin, M.D.

3rd Session: March 16, 1961

9:00 A.M. Physiology of Diuretic Therapy—Donald A. Roth, M.D.
9:30 A.M. Electrolyte and Water Imbalance in Congestive Heart Failure—Ben I. Heller, M.D.
10:00 A.M. Diagnosis of Renal Disease—Ben I. Heller, M.D.
10:30 A.M. Treatment of Chronic Renal Failure—Donald A. Roth, M.D.
11:00 A.M. Management of Diabetic Acidosis—John R. Peterson, M.D.
11:30 A.M. Auto-immune Hemolytic Anemia—Anthony V. Pisciotta, M.D.

4th Session: March 23, 1961

9:00 A.M. Allergic Disease and its Manifestations—John A. Arkins, M.D.
9:30 A.M. Oral Agents in the Treatment of Diabetes Mellitus—John R. Peterson, M.D.
10:00 A.M. Diagnosis and Treatment of Hypertension—Willard A. Krehl, Ph.D., M.D.
10:30 A.M. Present Trends in the Diagnosis and Treatment of Epilepsy—Warren H. Kempinsky, M.D.
11:30 A.M. Agranulocytosis—Anthony V. Pisciotta, M.D.

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Atelectasis in Newborn Infants

By F. HOWELL WRIGHT, M.D.

Chicago, Illinois

THE PROGRESSIVE decline of infant mortality rates in the United States reflects the success of public health controls and new therapeutic measures mainly applicable to infants between the ages of 1 and 12 months. Progress in the salvage of infants during the neonatal period has been considerably slower. Periodic analysis of infant deaths at the Chicago Lying-in Hospital repeatedly emphasizes the predominant role of respiratory failure. Practically every infant who succumbs is examined post mortem by Dr. Edith Potter's staff and the findings are correlated with the obstetrical management and the postnatal course in an attempt to understand the lethal factors and to identify those areas in which our knowledge and practice is deficient. An analysis of our experience during recent years shows that about two-sevenths of the deaths are due to congenital malformations and miscellaneous causes. Another seventh is primarily related to anoxia and birth trauma—a category which depends heavily upon the judgment, skill and attentiveness of the obstetrician in protecting the infant's interests through careful planning of the delivery, control of labor, the judicious use of anesthetics and analgesics, and immediate resuscitation after birth. The remaining four-sevenths of our infant deaths are ascribed primarily to inadequate pulmonary ventilation. More than half of these are among previable infants with immature lungs, and the rest are in larger premature and term infants with various types of intrinsic lung pathology. Obviously if any major reduction in neonatal mortality is to be achieved, it must come through a better understanding of the mechanism of pulmonary disease and a more rational approach to prevention and treatment.

Incomplete Maturation of the Lungs

Although there are a number of aspects of physiologic immaturity which contribute to the shaky prognosis of the extremely premature infant, the degree of development of the lung is the main determinant. Until the fetus reaches about 20 weeks, or a weight of approximately one pound, the lungs have only a primitive vascular bed, and extrauterine existence is impossible. Between 20 and 28 weeks the pulmonary capillaries begin to grow down along the branches of the bronchial tree toward the terminal alveolar ducts.

Presented at Milwaukee County Hospital, Milwaukee, Wisconsin, June 2, 1960.

Doctor Wright is chairman, Department of Pediatrics, University of Chicago, Bobs Roberts Memorial Hospital, Chicago.

Eventually these capillaries of the pulmonary bed push aside the cuboidal epithelium with which the ducts are lined and bring themselves into such close apposition to the potential air spaces that gaseous exchange can take place across a barrier which is scarcely thicker than the endothelium of the vessel itself. Before 28 weeks of age, or two pounds in weight, only a few infants will have completed enough vascularization of the lung to permit their survival for more than a few hours or days. In our premature nursery approximately 90% of infants born before this critical weight is reached will die; whereas, about 90% of premature infants who have passed this weight will survive. It is difficult to believe that this correlation between pulmonary development and mortality is accidental. The details of management of the previable infant are beyond the scope of this discussion. However, since our concern over retrolental fibroplasia has led us to abandon the routine use of oxygen, we have actually had a better survival rate among previable infants, although the operation of other factors makes it impossible to say that this change is solely responsible for the result. The ultimate remedy for previability must wait upon better methods of keeping the fetus *in utero* beyond the critical period of pulmonary development.

Aspiration of Amniotic Fluid

The role which the amniotic fluid plays in the initiation of pulmonary disorders in the newborn infant has been debated for many years. Before birth it is obviously in contact with the respiratory passages, but the degree to which it normally enters the alveoli by tidal flow, by diffusion or by inspiration during intrauterine respiration is not definitely known. Since any of these mechanisms of interchange are possible in *all* infants, it seems necessary to look for special circumstances to explain the occurrence of pulmonary disturbances in those few in whom aspirated amniotic fluid appears to be a factor. When squamous epithelial cells, shed from the body surface, are found in the pulmonary alveoli, the aspiration of amniotic fluid is clearly demonstrated. Occasional stillborn infants have lungs which are solidly packed with such debris. Presumably, in response to anoxia the fetal movements become more vigorous, the amount of desquamation is thus increased and intrauterine respiration is stimulated, drawing the churned amniotic fluid into the lungs. Perhaps embarrassment of the placental circulation also increases the absorption of amniotic fluid by the pulmonary circulation, creating a unidirectional flow into the lungs which concentrates the cellular elements within the alveoli. Such debris has been blamed for obstruction of alveolar ducts in neonatal atelectasis. In one infant who survived for 6 weeks and then died of a nonpulmonary cause, the lungs were found studded with small patches of consolidation which on microscopic examination revealed tiny healed granulomas about squamous epithelial cells. No one knows how often such lesions are responsible for the patches of atelectasis seen by x-ray in infants who survive early respiratory distress.

Infants who discharge meconium into the amniotic fluid before birth may have immediate or slightly delayed respiratory embarrassment. Meconium which cannot be retrieved by the tracheal catheter is usually incriminated either as a mechanical plug or as a chemical irritant. Most of such infants recover gradually over the first 4 to 5 days.

Retrograde infection of the amniotic fluid may occur in labors which are complicated by premature rupture of the membranes. Aspiration of infected fluid by the fetus results in pneumonia initiated before birth. Administration of a broad spectrum antibiotic to women whose membranes have been ruptured for 12 to 24 hours before delivery and continuation of a similar drug to the infant after birth may provide some protection against this misfortune. To be effective, however, such antibiotics must be given prophylactically and routinely, for the recognition of intrauterine pneumonia in the newborn infant is uncertain and is usually made too late for therapy to rescue him.

The Hyaline Membrane Syndrome

The factors which produce resorption atelectasis, or secondary atelectasis, or the hyaline membrane or respiratory distress syndrome, are not clearly understood. This pathologic picture is found with greatest frequency among viable premature infants who develop respiratory distress sometimes after a few hours of apparent well-being. It is also found among infants of diabetic mothers and some term infants, particularly when delivery has been effected by Cesarean section.

Baby Boy A. represents a typical case. He was born to a mother who had produced two

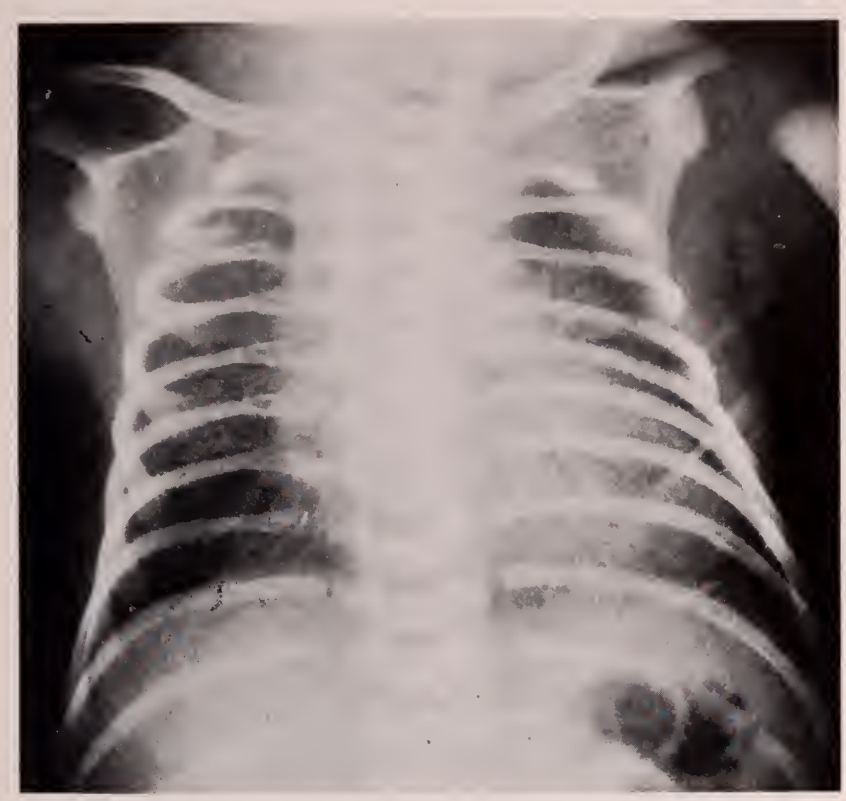

Fig. 1—Chest x-ray of Baby Boy A. taken at 6 hours of age. Typical hyaline membrane disease.

previous premature infants. Her pregnancy was uncomplicated until the onset of labor at 33 weeks. After a week of intermittent contractions, the membranes were ruptured artificially and the infant was delivered after 8 hours of steady labor. He weighed 2,335 gm. Respirations were established at once but after a short time dyspnea, costal retractions and mild cyanosis appeared. The symptoms progressed rapidly and cyanosis was only partially relieved by oxygen. At 6 hours chest x-rays were obtained which showed patchy granular atelectasis of the lungs (Fig. 1). In spite of increasing concentrations of oxygen up to 40%, his symptoms did not abate and he died of exhaustion at 33 hours of age.

Postmortem examination showed firm, congested, heavy lungs which contained little air and sank in water. Microscopically there was typical engorgement of the pulmonary vessels, widespread collapse of air spaces and large amounts of hyaline material within the alveolar ducts.

The pathologist who examines lungs such as these has no difficulty in understanding why the infant failed to survive. But it is more difficult to construct a completely satisfactory theory of pathogenesis against which to direct our therapeutic efforts. Originally, attention focused upon the composition and derivation of the hyaline membrane. Recent work indicates that it is composed, at least in part, of fibrin. But there is a growing suspicion that the membrane may not be the primary factor which acts to block alveolar ducts and obstruct gaseous diffusion, for the amount and distribution of the membrane is quite variable from one infant to another and within different areas of the same lung. Some now regard it as a more or less terminal phenomenon which follows when fibrinogen leaks from the local capillaries due either to congestion of the pulmonary circulation, or to tissue anoxia, or to the mechanical trauma of vigorous respiratory efforts. Thromboplastin from local tissue damage or from aspirated amniotic fluid could convert the fibrinogen to fibrin and the resulting coagulum may then be desiccated by the drying effects of hyperventilation or therapeutically administered oxygen. If this be the true significance of the hyaline membrane, then attention should be focused upon the reasons for pulmonary congestion or anoxia. Those who regard pulmonary vascular stasis as the primary fault suggest that some infants have difficulty in adapting to the adult type of cir-

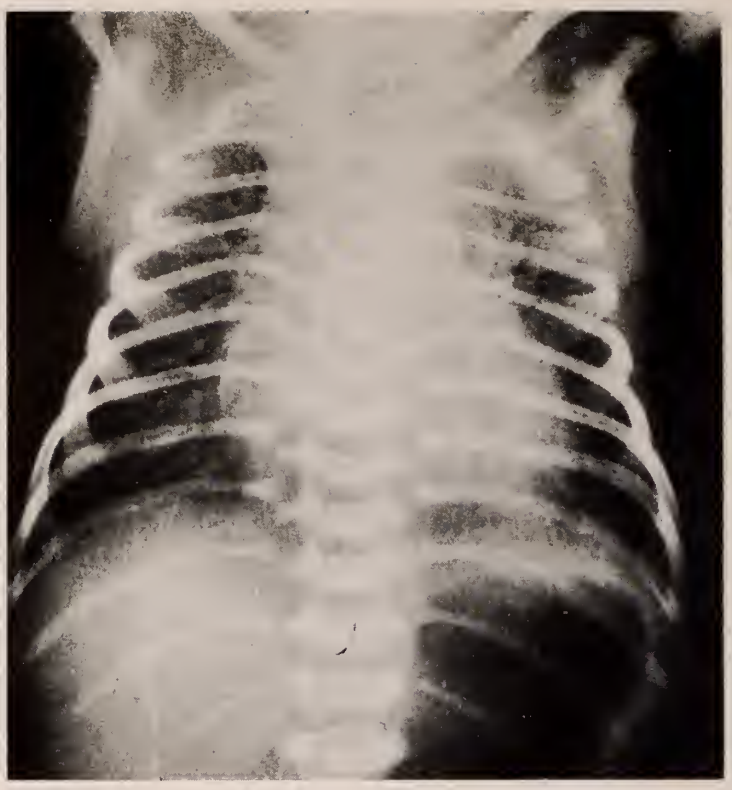

Fig. 2—Chest x-ray of Baby Boy F. taken at 6 hours of age. Generalized atelectasis with eventual recovery.

Fig. 3—Chest x-ray of Baby Boy M. at 18 hours of age showing atelectasis and emphysema. Recovery in 3 to 4 days.

culation; that a relative left-sided heart failure ensues with progressive accumulation of blood in the pulmonary circulation; and that this in turn encroaches slowly upon alveolar air spaces and fosters the transudation of protein and, secondarily, of membrane formation. Others believe that anoxia is the original insult, or that the blame lies within alveoli which fail to open up due to cohesiveness of their walls or to unequal inflation which leads to a combination of emphysema and atelectasis within adjacent units of the lung. Failure to acquire a sufficient ventilating surface then results in secondary anoxia and carbon dioxide retention which account for the membrane formation, for acidosis, and for hyperventilation.

Validation of any theory of hyaline membrane disease is complicated by the uncertainty of making a clinical diagnosis. The course, physical examination of the chest and x-ray changes are not sufficiently specific to permit us to decide whether one baby who recovers suffered a mild form of the same disorder to which another succumbed. Thus, it becomes difficult to evaluate the effect of modifications in management. Without pathologic confirmation can we justifiably say that the following infants recovered from hyaline membrane disease?

Baby Boy F. was the second of twins delivered by breech extraction after a 34-week gestation. His birth weight was 2,400 gm. He breathed and cried within one minute after delivery but remained cyanotic, had retractions of the costal cage and periodic brief periods of apnea. Except at the lung bases the entry of air into the chest seemed to be good. After one-half hour of oxygen administration, he improved; but cyanosis and grunting returned at 2 hours of age, and oxygen was resumed in low concentration. At 6 hours of age (Fig. 2) the chest x-ray showed generalized poor aeration of the lungs. No significant improvement occurred until he was 76 hours old when he suddenly became better and went on to complete recovery. A follow-up film at 100 hours failed to show very much change in the appearance of his lung fields.

Baby Boy M. was born at term to a primiparous mother who had bled during the first trimester of pregnancy and had suffered intermittent cramps throughout. After a 14-hour labor he was delivered by low forceps under ethylene anesthesia. Breathing and crying were delayed for 4 minutes and a tracheal catheter was used. Upon resuscitation he displayed chest retractions and mild cyanosis. Respirations were vigorous and the lungs seemed to aerate well. After 15 hours his cyanosis was gone but the retractions and rapid respiratory rate persisted. A film made at 18 hours of age (Fig. 3) showed diffuse patchy atelectasis with generalized emphysema. By 36 hours of age he was greatly improved and recovery ensued.

Baby Boy B. was delivered at term by elective Cesarean section. He cried and breathed at once but respirations were rapid and there was dullness and diminished breathing over the right upper lobe of his lungs. Cyanosis in air was relieved by administration of 30% oxygen. The chest x-ray (Fig. 4) obtained at 7 hours of age revealed poor aeration of the right lung. At the end of 24 hours his condition had improved and oxygen was discontinued. However, rales and rapid respirations persisted and he began to regurgitate small amounts of mucus. Suspecting pneumonia, antibiotics were begun, and another film was obtained at the age of 3 days. The lung fields seemed much improved but the infant slowly became worse. At the age of 6 days it became obvious that he had a pneumoperitoneum. Looking back at the first film we could see air beneath the diaphragm. Operation disclosed a perforation in the stomach which was closed. The infant recovered in spite of the fact that we had proof of the existence of peritonitis for at least 3 days.

Fig. 4—Chest x-ray of Baby Boy B. at 7 hours of age. Massive atelectasis of right lung. Air beneath the diaphragm cannot be seen well in the reproduction.

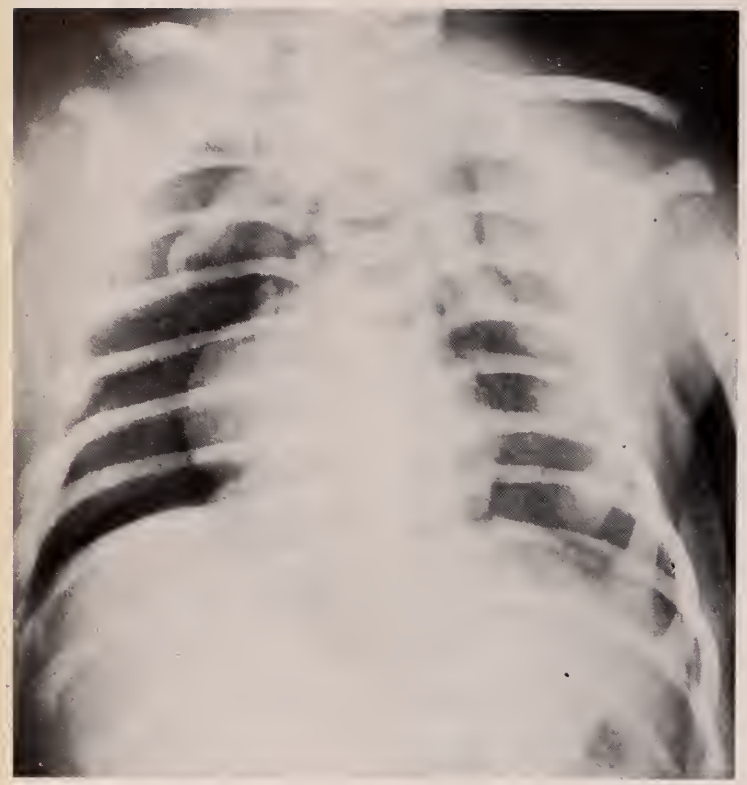

Fig. 5—A-P chest x-ray of Baby Boy M. at 5 hours of age showing interstitial air and right pneumothorax. Recovery without mechanical intervention.

Fig. 6—Lateral view of the chest of Baby Boy M. at 5 hours showing anterior mediastinal emphysema.

Because of such uncertainty about the pathogenesis of neonatal atelectasis and our inability to prognosticate the outcome for the individual infant, we have adopted conservative management which attempts to offer the child the maximum chance for spontaneous recovery. By the end of 48 hours in most, and 72 hours in all infants, the disease will pass its critical stage. Exhaustion from strenuous respiratory effort appears to be the limiting factor for many infants. Consequently we disturb them as little as possible. We omit feedings, remove pharyngeal secretions when necessary and watch for apneic episodes. Moist atmosphere is provided in an incubator, but supersaturated mists and inhalations of wetting agents have been given up since they provide no empiric advantages. Oxygen is used as sparingly as possible, never exceeding a measured 40% concentration. We think, but cannot prove, that there has been a decline in the incidence of fatal hyaline membrane syndrome since this policy was adopted a few years ago. Injectable antibiotics—penicillin and streptomycin—are given to forestall secondary bacterial infection of the lungs.

Interstitial Emphysema and Pneumothorax

Another general mechanism which embarrasses respiration in the newborn infant is the appearance of air in abnormal sites within the thorax.

Baby Boy M. was delivered with difficulty from a mother who had previously had an ectopic pregnancy. The gestation lasted 42 weeks before labor began. Delivery was accomplished after 22 hours with Dührssen's incision of the cervix and a hard pull with mid-forceps. The infant was covered with blood, some of which he aspirated into the trachea. Respirations were established after 1 or 2 minutes use of the tracheal catheter. He weighed 4,100 gm. and had yellow discoloration of the skin compatible with postmaturity. There was a bilateral cephalhematoma, facial edema, a partial facial paralysis and brachial palsy. The sternum appeared prominent but respirations were vigorous and regular and the lungs appeared to aerate well. However, the heart tones were thought to be shifted to the right and at 5 hours of age, chest x-rays were obtained which showed air in the fascial planes of the neck, the anterior mediastinum and the right pleural cavity (Figs. 5 & 6). Despite his numerous difficulties this infant improved progressively and made a full recovery.

The most plausible explanation for such a distribution of air in the thorax assumes that

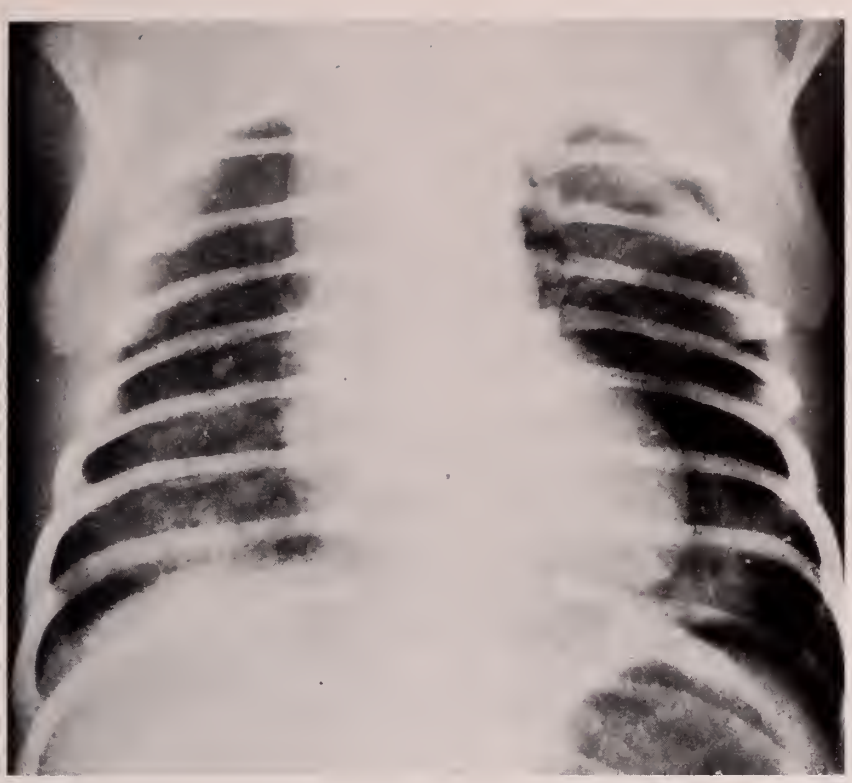

Fig. 7—A-P chest x-ray of Baby Boy R. taken on the third day of life showing residual air in left pleural cavity along cardiac border.

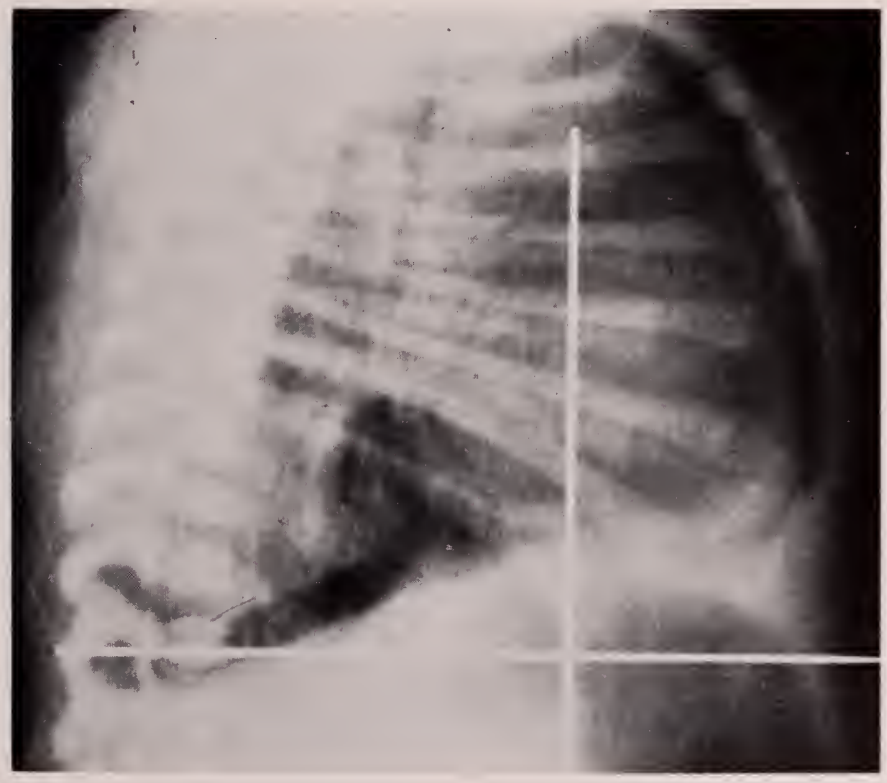

Fig. 8—Lateral view of the chest of Baby Boy R. on the third day of life. A band of air can be seen above the diaphragm and interstitial anterior mediastinal emphysema is present

Fig. 9—A-P chest x-ray of Baby Boy V. at 33 hours of age showing late appearance of anterior mediastinal emphysema.

an alveolus ruptures and admits air into the interstitial tissue of the lung or the adventitia of the pulmonary vessels while still inside the visceral pleura. During inspiration more air is drawn through the rent and with the external pressure of the expiratory phase it is milked along the pulmonary vessels toward the hilum of the lung. From thence it may gain access to the anterior mediastinum or extend along blood vessels or fascial planes usually into the neck but occasionally down into the abdomen or up under the scalp. From the root of the lung it may also break into the pleural cavity, usually affecting the contralateral side from that on which the initial interstitial emphysema appeared. Patchy or lobar collapse of the lung may follow when large amounts of air are thus introduced. Rarely the air is introduced under enough pressure to embarrass the flow of blood in the pulmonary vessels or drastically shift the mediastinal structures. Under such circumstances immediate relief of pressure by needle aspiration is indicated.

The force which produces alveolar rupture is usually assumed to be the vigorous overenthusiastic attempts to inflate artificially the lungs of an asphyxiated infant, such as the one just described. However, this case must be contrasted with the following:

> *Baby Boy R.* was delivered by Cesarean hysterectomy under spinal anesthesia without analgesia. He breathed and cried during the delivery and no resuscitation was used. However, his lungs aerated poorly and his respirations were rapid and grunting. After 2 days of slow improvement in 30% oxygen, chest films were obtained (Figs. 7 & 8) which showed residual mediastinal emphysema and a small pneumothorax. He recovered, and follow-up films at the age of 6 days showed resorption of the air.

The possibility that alveolar rupture may occur without artificial inflation of the lungs is enhanced by the findings of an unpublished study made some years ago at the Chicago Lying-in Hospital. Randomly selected infants who displayed no respiratory distress were examined radiologically on the first day of life. Approximately 10% were found to have anterior mediastinal emphysema and 1% had a clinically unrecognized pneumothorax. Occasionally in examining a presumably normal infant one stumbles across an area of subcutaneous emphysema in the neck or scalp which must originate from alveolar rupture at birth. The appear-

ance of air in the chest may be delayed as suggested by the following case:

Baby Boy V. was delivered with meconium-stained amniotic fluid, but breathed and cried at once and showed no respiratory distress until the age of 33 hours when dyspnea suddenly became apparent and diminished breath sounds were found over the right side of the chest. The films (Figs. 9 & 10) revealed a pneumomediastinum with compression atelectasis of the lung. After 2 days the roentgen findings and the symptoms disappeared.

Except when mediastinal emphysema or pneumothorax result in mounting tension within the thorax, the prognosis for recovery is good. Symptomatic support and antibiotic protection against infection are all that are likely to be required.

Intrathoracic Anomalies

Finally, the possibility of anomalous development of the thoracic organs must always be kept in mind when dealing with a dyspneic newborn infant.

Baby Boy Z. was delivered at term following a normal pregnancy. He breathed and cried within 1 minute. His hands and feet were blue shortly after delivery, but the examination of his heart was considered normal. At 3 hours of age he had a cyanotic spell and was placed in oxygen which relieved the cyanosis. At 5 hours of age the left side of the chest was found to be hyperresonant and the heart tones were best heard to the right of the sternum. A chest x-ray (Fig. 11) showed intestinal loops in the left side of the thorax and displacement of the heart to the right. Operation for diaphragmatic hernia was successfully completed but he died unexpectedly a few hours later. At autopsy herniation of his heart through an unrecognized congenital defect in the pericardium was discovered.

Other anomalies which may be associated with hypoplasia of the lung include anencephaly, renal agenesis and polycystic kidneys. Cystic lung disease and enterogenous cysts may cause dyspnea by occupying space in the thorax. The differential diagnosis of congenital malformation of the heart is, of course, a large separate problem in itself.

Conclusion

The foregoing are some of the considerations which a physician must juggle in his mind as he attempts to evaluate a dyspneic newborn infant. A clear understanding of

Fig. 10—Lateral view of the chest of Baby Boy V. at 33 hours showing mediastinal emphysema.

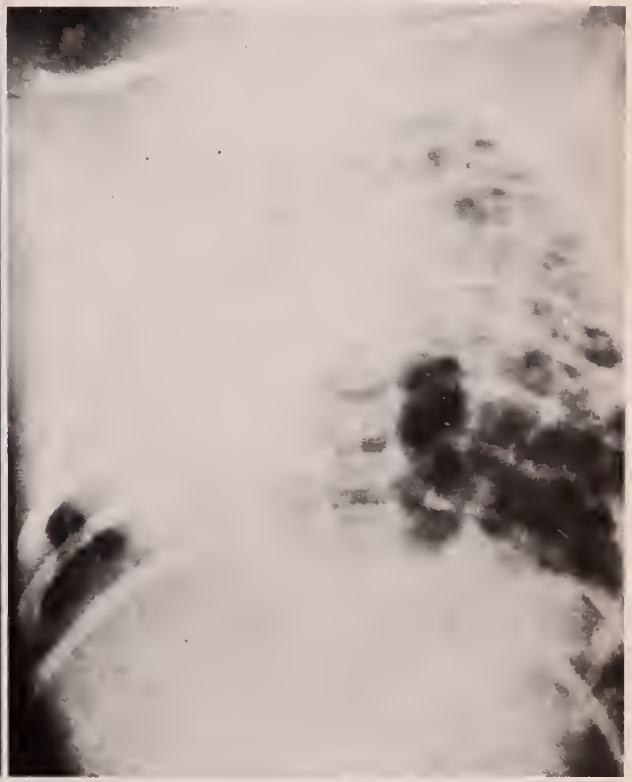

Fig. 11—Chest x-ray of Baby Boy Z. at 5 hours of age showing left thorax filled with intestinal loops and compression atelectasis of right lung.

the clinical problem is often thwarted by limitations of physical examination and an incomplete history of the details of labor and delivery. Some types of pathology can be ruled out if adequate anteroposterior and lateral x-rays of the chest can be obtained without undue manipulation of the infant. Empiric rules of management should include the maintenance of a clear airway, moist atmosphere, adequate antibiotic coverage and as low a concentration of oxygen as will relieve cyanosis. Above all, the infant's energy should be conserved through minimum handling and avoidance of fruitless manipulations. When the doctor is unable to understand an infant's difficulties completely or to supply an effective remedy, he should at least make sure that the infant has every chance to unravel his physiologic handicaps through his own efforts.

920 East 59th Street (37).

Rupture of the Uterus

Rupture of the uterus accounted for 10.7 per cent of the maternal deaths in Michigan due to direct obstetric causes during the years 1950 to 1957 inclusive.

Precipitating factors which we have found in the study of these cases include previous Cesarean section, induction of labor by pitocin, intrapartum pitocin stimulation, version and extraction, forceps delivery and spontaneous precipitate delivery. It is especially interesting to note that 27 of the 77 maternal deaths from rupture of the uterus followed spontaneous delivery, five of which were breech presentations.

Advancing parity which goes hand in hand with advancing obstetrical age is the first warning sign. Of patients who died from uterine rupture, 57 per cent were 30 years of age or older; 88 per cent were multiparous and 34 per cent were para 5 or more.

Another interesting finding was the lack of good prenatal care which was evident from the records. Of the 77 patients who died 68 per cent had either little or no prenatal care.

There are two other statistics which help in telling why death so often follows rupture of the uterus. Of the 77 patients who died, only 31 had a pelvic examination and there were but 29 hemoglobin examinations performed. These are also indications of the type of prenatal care which the patients received.

There are unpreventable deaths due to rupture of the uterus but these in modern times are rare indeed.

Prevention of rupture of the uterus has its beginning with good prenatal care. With strict adherence to the rules for pitocin induction and stimulation, the general rule once a Cesarean section always a Cesarean section, the abolishment of version and extraction as a mode of delivery, and the use of forceps only by the well-trained, the number of uterine ruptures will rapidly diminish.

To decrease the number of deaths from rupture of the uterus, blood in adequate amounts should be readily available in every hospital doing obstetrics. *Every* cervix should be inspected following delivery. *Special* consideration must be given to the multiparous patient over 30, following precipitous or breech delivery, the use of pitocin for induction or stimulation, or following any operative or traumatic delivery such as forceps, extractions, or unusual fundal pressure as would be encountered with shoulder dystocia.

Manual exploration of the uterus, carefully done, is no longer feared and is often a life-saving procedure. A warning should be stressed that frequently small ruptures are not easily detected. Consultation should be considered for patients with excessive bleeding, a rise in pulse rate, a drop in blood pressure or persistent pain in the pelvis, abdomen or flanks.

One final statistic: only 23 babies in this series of 77 maternal deaths survived.—OBSTETRICAL BREVETS, *Michigan State Medical Journal* 59: 1266 (Aug.) 1960.

Resuscitation of the Newborn Infant

By WILLIAM KREUL, M.D.

Racine, Wisconsin

INFANT MORTALITY rates during the first year of life have shown a steady decline in the last several decades. The death rate associated with birth and the immediate neonatal period has not dropped in proportion. During this time many devices for resuscitation have been designed and many techniques recommended without materially changing the statistics.

The first three minutes of extrauterine life are urgent. This is the period before mechanical devices of resuscitation are put into use. This is the period when the obstetrician is charged with the responsibility of assisting nature initiate respiratory activity and with the responsibility of *not* handicapping nature's efforts. The latter is more important than the former. The thread of life at certain moments in our existence can be incredibly thin. Deterioration in the apneic state under any circumstance is very rapid. A minute or two is of paramount importance. The spending of that minute in waste and harm or in profit can be the determinate of life or death.

Resuscitation of the newborn infant may be divided into three parts: (1) predelivery evaluations and prevention of depression of the infant, (2) clearing of the airway and administration of oxygen, (3) application of mechanical devices to obtain oxygenation until respirations do so. The first two properly done will eliminate the need for the third in most cases and therefore constitutes the subject of this paper.

Predelivery Evaluations and Prevention

Evaluation of the fetus and its mother is not a one-time thing. At the first prenatal visit the mother's medical history is obtained for possible heart disease, kidney disease, hypertension, anemia, diabetes and other conditions. If the fetus is to prosper, any disease present in the mother must be studied, treated and controlled. In multipara detailed knowledge is obtained concerning difficult labors, difficult deliveries, size of infants at birth, toxemias, Rh factor and related conditions. The physical examination is thorough and reinforces the findings of the history. Thus, with a base line established and both general and specific dietary and hygienic regimens spelled out to the patient, reevaluation continues visit-to-visit throughout the pregnancy, labor and delivery.

A common cause of newborn depression is the analgesics and sedatives received by the mother. The patient who is without fear, confident of her own and her doctor's ability, will be cooperative and require minimal analgesics and anesthetics. Therefore, a sincere effort to build this confidence and gain understanding and rapport should be made at each prenatal visit. *The prevention of drug depression of the newborn infant begins with the first prenatal visit.*

At the onset of labor all information about the patient should be on hand and reviewed in order to help the infant as well as the mother lest nine months be wasted, or worse, end in a living tragedy of retarded mentality. During labor the prescribing of sedatives and analgesics needs careful estimation and supervision. Routine orders are to be decried. At many hospitals doctor's order cards standardize drugs and dose according to the progress of labor. These are a travesty on the state of our knowledge. Each patient and each dose should be individualized. Doses will depend on the tolerance threshold of the mother to her pain, her apprehension and the drug, and her size and the state of her health. The infant must be considered also according to size, maturity and general condition as evidenced by its activity in utero, the heart rate and heart tones. A balance must be sought so that the infant will not suffer depression unduly for the comfort of the mother.

Drugs should be selected according to the need of each patient at the time. A calm stoical woman does not need sedatives and only small doses of analgesics. A sensitive

Presented at the Institute on Problems of the Newborn, Milwaukee County Hospital, Milwaukee, June 2, 1960.

but calm, well-orientated woman needs pain relief with little or no sedation. In fact sedatives may take away her inherent ability to bear pain and then she will require excess analgesics. Sedatives should not be used when analgesics are indicated because their ability to relieve pain is nil until the total dose is so large that unconsciousness supervenes. In like manner analgesics should not be given when sedation is needed. Their ability to sedate is poor and may reduce the strength and frequency of uterine contractions. Doses of both analgesics and sedatives should be small, repeated at short intervals of 60 to 120 minutes as indicated.

Estimation of the probable depression of the infant by the drugs given to the mother unfortunately does not follow a formula. Difficulties arise due to individual susceptibility of infant and mother and due to factors of time and dosage. However, the total dose of the depressant drugs is a starting point modified by clinical assessment of the mother on the basis of her memory, speech, ataxia, ability to follow orders, sleepiness, degree of uninhibited response to pain, and respiratory depth and rate. The effect of the total dose of depressants depends on the period of time over which they are given and on the severity of pain being controlled; the more severe the pain the greater the amount of analgesics required and tolerated without marked depression. But it must not be assumed that the infant will not be depressed in the latter instance or that an infant will share the high tolerance of its mother. A single dose of an analgesic or hypnotic three or more hours before delivery may result in a depressed infant simply because the child is unusually susceptible to the drug. A relatively large total dose of depressant drugs given more than four hours before delivery is not innocent of depression by virtue of the four-hour interval because these drugs are additive and cumulative. The clinical assessment described above is helpful and if applied at intervals during labor, will prevent excessive depression of the mother and in all probability, the child. Because there is individual response to drugs, fractions of the recommended therapeutic dose given at shorter intervals allow a better hour-to-hour control of pain, and more important, of depression.

Other factors produce depression. Too often these are all but forgotten. A long labor may produce a depressed infant apart and above that to be expected from the drugs given to the mother. Severe uterine contractions even for short periods contribute to depression. Difficult forceps or extraction do so to a marked degree. The small and the premature are uncommonly susceptible to the causes of depression. The breech presentation is a well-known problem.

A comprehensive and critical evaluation, besides causing the obstetrician to be on guard for the need of resuscitation, makes possible an intelligent selection of the method of anesthesia. When the probability of depression is great or depression must be kept to a minimum, conduction anesthesia such as local infiltration, pudendal and spinal is preferred. If general anesthesia is mandatory for a valid reason, the correct timing to avoid depression of the infant by the anesthetic agents given to the mother can be the difference between spontaneous respirations and the necessity for resuscitation that may or may not be successful.

The predelivery evaluation of the probable state of the infant will indicate the expected need for resuscitation. The obstetrician can arrange in advance and be conditioned to take the various steps in the resuscitation of the newborn infant in a careful, rapid but unhurried manner following a "by-the-clock" sequence.

Early Resuscitation

The first three minutes of extrauterine life are critical. The outcome is decided during that time. Everything that is done for the infant should be favorable and nothing that is detrimental should be permitted.

Suspension of the infant at the ankles is a vicious practice. It becomes doubly so when the head of the infant is allowed to rest upon the delivery or instrument table in acute flexion, thereby causing obstruction of the airway. The triple threat is seen when the aspirating bulb is used in the pharynx repeatedly in quick succession over a period of time, reflexly inhibiting the initiation of breathing. One, two or all of these practices are seen too often in the average delivery room.

The custom of upending the infant immediately after birth stems from an overpowering desire to prevent aspiration of the pharyngeal contents. Actually a maximum of 15 degrees Trendelenburg position is adequate to accomplish this and will not inhibit respirations. Consider that the child has not

breathed and the first act of respiration will be inspiration. The ordinary stimulus of the Hering-Breuer reflex to expire follows stretching of the chest. Upending the child stretches the chest strongly giving a stimulus for expiration when inspiration is wanted. The inhibition so established may delay the onset of respirations. The delay may be critical and a minute later the infant may not be able to respond to the normal stimuli for respiration due to the depression of additional oxygen lack and carbon dioxide accumulation.

During inspiration the contraction of the diaphragm always plays a strong and primary role that is greatly exaggerated in exerting the 20 to 30 cm. of water pressure required to overcome the atelectatic state of the lungs at birth. In the upside-down position the initiation of respirations is further impeded by the weight of the abdominal contents—a disproportionately large liver, the stomach and intestines, and the spleen—upon the diaphragm. In addition the chest that normally rises upward and outward in inspiration must literally raise the body on itself.

Experiments in the adult have clearly shown that more than a 15-degree Trendelenburg position is detrimental to the cardiovascular system and markedly reduces respiratory volume. There is no reason to believe that the infant is different in this respect. A depressed newborn infant for whatever reason is in incipient shock. Frank shock difficult to recognize may supervene so that resuscitation fails completely or leaves a precarious state that ends in death some hours or days later. A 15-degree Trendelenburg position will drain the respiratory tree and prevent aspiration. Holding the child with the neck and head cradled in the palm of the left hand and the spine lying along the forearm offers the best controllability. Aspiration of the pharynx may be done with the right hand while the head is held in mild extension. Positioning is merely a matter of habit and the time consumed is negligible.

Clearing the airway of the upper respiratory tract should be done promptly and carefully in an unhurried manner. Aspiration of the pharynx via the mouth and aspiration of the nasopharynx via each nostril and then again aspiration of the pharynx should constitute the initial effort. Repeated and traumatic aspirations of the pharynx irritate the mucous membrane and set up reflexes that inhibit respirations. Because the epiglottis and glottic structures are shallowly placed in the pharynx of the infant, laryngospasm may be initiated by the exploring tip of the bulb syringe or catheter. The airway *must* be cleared of secretions and debris, *but* traumatic, unnecessary or prolonged manipulations are to be avoided.

Whether further aspirations are needed depends largely on the amount and quality of the secretions obtained. Careful observation of the products of each aspiration is necessary rather than blind repetition. Few infants have sufficient secretions to warrant wasting time if respirations have not begun spontaneously as yet. If respirations have begun, then enough time should be allowed for them to become established and oxygenation accomplished unless secretions are obviously excessive and interfering with respiratory exchange. If the latter is true, as determined by the color of the child, by the amount of secretions removed at the preceding aspiration and by the moist sound of respirations, then aspirations must be continued but several breaths allowed between pharyngeal aspirations. When the infant is properly positioned as described above, the nasopharynx acts as a reservoir and the secretions from this reservoir can be removed via the nares. In this manner pharyngeal stimulation and irritation will be minimized while the infant is trying to establish respirations.

From the moment the head of the infant passes through the external orifice of the vagina, close observation must determine whether the single inspiratory gasp that obliterates the atelectatic state of the lung has taken place. The outlook of the child who has taken that gasp is excellent in spite of the state of depression. Such a child can be supported with artificial respiration until the depression has passed. Oxygenation can be attained but the method applied must be effective.

Between these maneuvers of clearing the airway, gentle skin stimulation may be used. Rubbing the skin over the vertebral spine or over the ribs and flicking the sole of the foot may initiate respirations. More drastic methods such as spanking, warm and cold tubbings, jackknifing, and swinging are to be vigorously condemned. All of these methods traumatically depress the vascular

system to the point of shock and may break the thread of life.

As the child is expelled or removed from the uterus, the latter contracts and disrupts the maternal blood supply to the placenta. In fact in 80% the placenta is found free in the lower uterine segment immediately following the birth of the child. Therefore asphyxia of the newborn infant begins *before* birth and is a normal accompaniment *of* birth. Asphyxia is progressive so long as the infant remains apneic because oxygen is being used out of the circulating blood without replacement and carbon dioxide is being accumulated in the circulating blood without excretion. Both oxygen lack and carbon dioxide accumulation are depressing to all cells but especially to those of the vital centers controlling the respiratory and vascular systems. After a time these centers will be unable to respond to the usual and normal stimuli to their function. Oxygen should be supplied to the infant early in resuscitation. Why not have oxygen available at the instrument and delivery table? Complete oxygenation of the newborn infant should be obtained as soon after birth as possible to eliminate central depression due to hypoxia. A minute or two or three of oxygen will not harm any infant—not even a premature.

With the infant on its side and its head in mild extension to secure a patent airway, oxygen will be blown into the respiratory passages by a flow of 4 or 5 liters of oxygen per minute via a funnel or mask applied loosely to the face. Very often in the depressed infant, extremely shallow respirations that are visible only with the closest scrutiny are present. The infant though unable to oxygenate on the 20% oxygen of the air will do so on the near 100% supplied. As soon as the degree of hypoxia is lessened, the respiratory center becomes less depressed and respirations become deeper. The trend is reversed and soon becomes apparent.

For the completely apneic child who has not responded to the measures heretofore discussed, mouth-to-mouth resuscitation should be undertaken. Careful observation of the infant's chest will indicate whether the airway is clear. If not, placement of an endotracheal tube is mandatory and mouth-to-tube resuscitation done.

Late Resuscitation

There are more than a hundred different methods of resuscitation involving special equipment. All have advantages and disadvantages that make them more or less suitable under varying circumstances. The value of each depends on the knowledge and ability of the operator to use them and on their availability.

Summary

Resuscitation of the newborn infant is arbitrarily divided for emphasis into three parts: (1) prenatal care and evaluations with probable need for resuscitation, (2) early resuscitation of clearing the airway and supplying oxygen, (3) late resuscitation with the aid of mechanical devices.

The practices that handicap the newborn infant in its efforts to initiate respirations with the reasons are discussed. The manner of clearing the airway that will permit respirations to begin is outlined. The infant's early need for oxygen is stressed.

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100 12th Street.

N. B. Especially recommended booklet entitled: "Resuscitation of the Newborn Infant" obtainable from the American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Illinois.

A Follow-up Study of Arterial Reconstructive Procedures in Arteriosclerosis Obliterans

By JOHN T. PHELAN, M.D.
Madison, Wisconsin

ARTERIOSCLEROSIS obliterans is a diffuse degenerative arteriopathy of the aorta and its branches. It is characterized by occlusive atheromatous lesions of the intima, fibrosis and calcification of the media, intraluminal thrombosis and, less commonly, aneurysmal dilatation. In many instances this process is segmental and is most often observed in the abdominal aorta, the common iliac artery and the superficial femoral artery in the region of the adductor canal. Because of this localization, arterial reconstructive procedures have been devised to: (a) remove the intraarterial block by thromboendarterectomy, and (b) employ vessel grafts—arterial and venous, autogenous and homologous, and cloth prostheses to replace or bypass the obstructed or diseased segment. During the last five years, these surgical techniques have markedly altered the management of peripheral arterial blockage due to arteriosclerosis, and like any new surgical method, their continued use requires a knowledge of the end results to be expected.

It is the purpose of this paper to review and analyze the results of these new procedures in 28 consecutive patients and to set forth certain opinions on the present position of surgical therapy for peripheral arteriosclerosis obliterans.

Material

Thirty-one operations were performed on 28 patients; one patient underwent two procedures on the same extremity. The ages of the patients ranged from 47 years to 78 years. Of the 28 patients, 24 were over 65 years of age, and all but 3 were males. The distribution of the arterial lesions were as follows: infrarenal abdominal aortic aneurysm (7 patients), aorto-iliac and/or iliofemoral artery obstruction (10 patients), and superficial femoral artery occlusions (11 patients). All operations were performed between October, 1957, and January, 1960.

Abdominal aortic aneurysm: The chief complaint of the 7 patients with infrarenal abdominal aortic aneurysm was abdominal, flank, and/or back pain of varied intensity and duration. Other manifestations included acute pain over the aneurysm, enlargement of the abdomen, and a pulsatile abdominal mass that was more distinct on the left side of the abdomen. In each case simple roentenography of the abdomen demonstrated the calcified wall of the aneurysm. Two patients were admitted to the hospital in shock from rupture of their aneurysms and required immediate surgery; the remaining patients were treated as elective surgical patients.

As noted in Figure 1, all of these patients were over 60 years of age, and each had moderate to severe hypertension. Other concomitant diseases were: (a) intermittent claudication (2 patients), (b) abnormal electrocardiograms (4 patients), and (c) elevated blood urea nitrogen and low fixed urine specific gravities (2 patients). In the latter 2 patients the suprarenal portion of the abdominal aorta was dilated to twice the normal at the time of surgery.

The two patients who entered the hospital with rupture of their aneurysms were treated by immediate resection and grafting, however both patients died within 48 hours from irreversible shock. One of these patients had an associated thoracic aortic aneurysm and had knowledge of both conditions for a period of three months. The other patient had no symptoms of his aneurysm prior to the time of rupture.

Of the remaining 5 patients, each survived their operation and were discharged from the hospital following a normal postoperative convalescence. However, one patient died within six months from cardiac failure, and another died four months later following a cerebral vascular accident. Three

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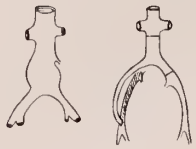
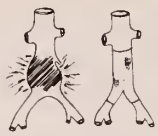
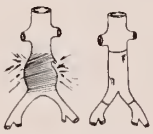
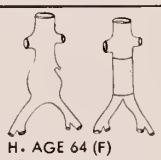
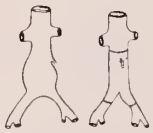
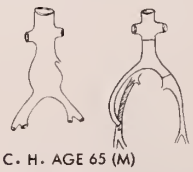
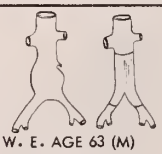
OPERATIVE FINDING AND TREATMENT	ASSOCIATED DISEASES	RESULTS
 A. B. AGE 68 (M) TEFLON GRAFT	1) HYPERTENSION 2) E. C. G. SHOWED VENTRICULAR PREPONDERANCE	ASYMPTOMATIC. PATIENT DIED AT HOME 4 MONTHS POST- OPERATIVELY. CAUSE UNKNOWN
 R. M. AGE 65 (M) RUPTURED ON ADMISSION TEFLON GRAFT	HYPERTENSION	DIED 48 HOURS POST-OPERATIVELY IN IRREVERSIBLE SHOCK.
 E. S. AGE 67 (F) RUPTURED ON ADMISSION TEFLON GRAFT	1) THORACIC AORTIC ANEURYSM 2) HYPERTENSION	DIED 48 HOURS POST-OPERATIVELY IN IRREVERSIBLE SHOCK.
 C. H. AGE 64 (F) AORTIC HOMOGRAFT	1) HYPERTENSION 2) E. C. G. SHOWED ISCHEMIC CHANGES 3) INTERMITTENT CLAUDICATION	LIVING AND WELL 23 MONTHS LATER. ? DILATION OF GRAFT.
 F. M. AGE 74 (M) NYLON GRAFT	1) HYPERTENSION 2) E. C. G. SHOWED OLD POSTERIOR WALL MYOCARDIAL INFARCT. 3) INTERMITTENT CLAUDICATION	LIVING AND WELL 19 MONTHS LATER.
 C. H. AGE 65 (M) TEFLON GRAFT	NONE	ASYMPTOMATIC 18 MONTHS
 W. E. AGE 63 (M) DACRON GRAFT	1) HYPERTENSION 2) E. C. G. SHOWED ISCHEMIC CHANGES	ASYMPTOMATIC. PATIENT DIED AT HOME 6 MONTHS POST-OPERATIVELY FROM A MYOCARDIAL INFARCTION.

Fig. 1—The number of cases of infrarenal abdominal aortic aneurysm treated by direct surgery.

patients are alive and well, one for 22 months, one for 19 months and another 18 months.

COMMENT: It is generally recognized that abdominal aortic aneurysms are a threat to life and, according to Estes, 50% of patients will die from rupture of their aneurysms within three years from the time of their recognition. In this group of patients it was difficult to assess when symptoms referable to the aneurysm began; in most cases the symptoms were vague; and only when a pulsatile, painful, abdominal mass was detected, was the condition recognized.

At present, most authors believe the treatment of symptomatic abdominal aortic aneurysm is surgical extirpation followed by replacement with a Dacron or Teflon prosthesis. As noted in Figure 1, when this was undertaken as an elective procedure, the immediate postoperative results were excellent; however, once rupture had taken place, the outcome was most ominous since death occurred in the 2 patients during the early postoperative period.

Whether all infrarenal abdominal aortic aneurysms should be resected is still a matter of conjecture. According to Crane,[2] aneurysms in this region which are less than 6 cm. in diameter enlarge slowly, therefore their early removal is not imperative. The Toronto group believes surgery is contraindicated in patients 75 years of age or older because of the severity of the associated generalized arteriosclerosis. Suffice it to say, these are narrowed limitations but are applicable if one assumes the mere presence of an aneurysm is not a primary indication for active treatment. In my opinion, once the aneurysm becomes symptomatic, the chance of rupture and death is imminent; and energetic treatment, irrespective of age and of the size of the aneurysm, is justified.

Aorto-iliac, iliofemoral and superficial femoral artery occlusion: The major presenting symptom of the 21 patients with aorto-iliac, iliofemoral and superficial femoral artery obstruction was intermittent claudication. This symptom varied with each patient, but was severe enough to make the patients seek medical advice. Other manifestations indicating more severe ischemia were as follows: rest pain (12 patients) and gangrenous digits and ischemic foot ulcers (7 patients). In addition, 13 of the 21 patients had clinical as well as laboratory evidence of arteriosclerotic changes involving either the myocardium or the cerebral or renal systems. Diabetes mellitus was present in 2 patients.

The location of the claudication pain was highly suggestive of the proximal level of the arterial occlusion. Hip and buttock pain was pathognomonic of iliac artery obstruction and when bilateral indicated aorto-iliac occlusion. Calf pain, although present in all cases of superficial femoral artery occlusion, was also observed in patients with higher obstructions. The presence of palpable pulses was the principal objective measurement in determining the level of occlusion and was also the determinant factor in selecting the site for arteriography. When a femoral artery pulse was present and if an occlusion proximal to the femoral artery was not clinically suspected, a percutaneous femoral arteriogram was performed. Inability to detect a femoral artery pulse indicated occlusion at the aorto-iliac level alone or in combination with a superficial femoral artery obstruction. Initially, a lumbar aortogram was performed in these patients; however, visualization of the distal arterial tree was generally inadequate by this method. During the last 12 months of this series, lumbar aortography was performed in only a few instances where an aorto-iliac obstruction was clinically diagnosed; and when practical the patients were taken to surgery, the superficial femoral artery exposed in the groin and a direct femoral arteriogram performed. If the superficial femoral artery was found obstructed and the popliteal artery patent, a femoral-popliteal artery bypass was done in addition to an aorto-iliac reconstructive procedure.[3]

In all cases, arteriography was used primarily to determine the patency of the distal arterial tree rather than the level of the obstruction; and when the popliteal artery and one of its branches was found patent, the patient was considered to be anatomically a candidate for an arterial reconstructive procedure.

The intraarterial blocks determined by arteriography were as follows: aorto-iliac, 7; iliofemoral, 4; superficial femoral artery, 10. In three instances bilateral superficial femoral artery occlusion was observed.

The arterial reconstructive procedures used in this group of patients are listed in Figures 2 and 3. The details of the operative techniques were essentially those described

OPERATIVE FINDING AND TREATMENT	CHIEF COMPLAINT	ASSOCIATED DISEASES	RESULTS
F. H. AGE 63 (F) ARTERY HOMOGRAFT	1) INTERMITTENT CLAUDICATION 2) ISCHEMIC FOOT ULCER 3) REST PAIN	1) AURICULAR FIBRILLATION 2) MYOCARDIAL INFARCTION, OLD 3) DIABETES MELLITUS	1) ASYMPTOMATIC 12 MONTHS 2) ULCER HEALED
F. U. AGE 65 (M) NYLON GRAFT	1) INTERMITTENT CLAUDICATION 2) ISCHEMIC HEEL ULCER 3) REST PAIN	E. C. G. EVIDENCE OF OLD POSTERIOR WALL MYOCARDIAL INFARCTION	1) ASYMPTOMATIC 21 MONTHS 2) ULCER HEALED
W. J. AGE 55 (M) NYLON GRAFT	INTERMITTENT CLAUDICATION	NONE	ASYMPTOMATIC 19 MONTHS
L.W. AGE 46 (M) THROMBOENDARTERECTOMY	1) INTERMITTENT CLAUDICATION 2) ISCHEMIC FOOT ULCER 3) REST PAIN	NONE	1) ASYMPTOMATIC 12 MONTHS 2) ULCER HEALED
C. M. AGE 43 (F) TEFLON GRAFT	INTERMITTENT CLAUDICATION	NONE	ASYMPTOMATIC 4 MONTHS
W. W. AGE 45 (M) THROMBOENDARTERECTOMY ARTERY HOMOGRAFT	1) GANGRENOUS, INFECTED AMPUTATION SITE, LEFT LEG. 2) REST PAIN, LEFT LEG.	NONE	OCCLUSION OF GRAFT POST-OPERATIVE. ABOVE KNEE AMPUTATION.
R. G. AGE 48 (F) ARTERY HOMOGRAFT	1) REST PAIN 2) FLEXION CONTRACTURE OR RIGHT KNEE 3) PREVIOUS AORTO-ILIAC THROMBOENDARTERECTOMY WITH REOCCLUSION	NONE	RETURN OF PERIPHERAL PULSES. PATIENT DIED ON 8TH POST-OPERATIVE DAY FROM PULMONARY EMBOLUS.

Fig. 2—The number of cases of aorto-iliac and iliofemoral artery occlusion treated in this series **(continued on next page).**

Fig. 2 (continued)

OPERATIVE FINDING AND TREATMENT	CHIEF COMPLAINT	ASSOCIATED DISEASES	RESULTS
W. L. AGE 55 (M) THROMBOENDARTERECTOMY TEFLON GRAFT	INTERMITTENT CLAUDICATION	NONE	ASYMPTOMATIC 12 MONTHS
T. R. AGE 54 (M) TEFLON GRAFT	1) INTERMITTENT CLAUDICATION 2) REST PAIN	NONE	ASYMPTOMATIC 9 MONTHS
P. R. AGE 50 (M) TEFLON GRAFT	INTERMITTENT CLAUDICATION	NONE	ASYMPTOMATIC 8 MONTHS

by DeBakey.[4] Thromboendarterectomy was performed according to the method of Cannon, et al.[5] During the first 6 months of this series (6 patients), homologous artery grafts were employed; however in the last 18 months, Nylon, Dacron, or Teflon artery prostheses were used. In 3 cases autogenous vein grafts were employed.

The results of these procedures in aorto-iliac and iliofemoral artery obstruction were quite satisfactory. In this series, one patient has been followed for 24 months, one for 20 months, one for 19 months, and two for 12 months, and three patients have been followed for less than 12 months; each patient has had return of peripheral pulses, and when present, relief of rest pain and healing of ischemic foot ulcers.

The one patient who died in this group had had an unsuccessful thromboendarterectomy of the aorto-iliac area one year previously; when seen later by me, the right leg was markedly ischemic, a flexion contracture of the knee was present and the patient required opiates for relief of her ischemic pain. A homograft was inserted from the right common iliac artery to the distal third of the superficial femoral artery. Immediately following surgery peripheral pulses were detected; however, on the eighth postoperative day the patient died suddenly, presumably from a massive pulmonary embolus. The lone limb lost in the group occurred in a patient who two months previously required an above-knee amputation of his left leg. On admission the amputative site was infected and gangrenous, and the patient was experiencing rest pain in his right leg and foot.

A lumbar aortogram revealed an aorto-iliac obstruction; however, the superficial femoral artery was incompletely visualized. At surgery the aorto-iliac obstruction was excised, the left common iliac and external iliac artery were treated by thromboendarterectomy and arterial continuity established with an artery homograft anastomosed to the abdominal aorta, left common iliac, and right superficial femoral artery. Within 24 hours the graft became occluded and an above-knee amputation was required. On examination of the amputated limb, the distal third of the superficial femoral artery was occluded. This area had not been visualized by the previous aortogram.

OPERATIVE FINDING AND TREATMENT	CHIEF COMPLAINT	ASSOCIATED DISEASES	RESULTS
R. T. AGE 59 (F) ARTERY HOMOGRAFT	1) INTERMITTENT CLAUDICATION 2) REST PAIN 3) GANGRENOUS 5TH TOE	1) HYPERTENSION 2) DIABETES MILLITUS	1) GRAFT OCCLUDED 4 MONTHS POSTOPERATIVELY. 2) TRANSMETATARSAL AMPUTATION REQUIRED.
F. L. AGE 68 (M) ARTERY HOMOGRAFT	1) INTERMITTENT CLAUDICATION 2) REST PAIN 3) ULCERATION OF RIGHT BIG TOE	1) HYPERTENSION 2) AURICULAR FIBRILLATION	1) GRAFT BECAME INFECTED AND AK AMPUTATION REQUIRED ON 5TH POSTOPERATIVE DAY.
C. C. AGE 78 (M) AUTOGENOUS VEIN GRAFT	1) INTERMITTENT CLAUDICATION 2) GANGRENOUS FOOT 3) REST PAIN	1) HYPERTENSION 2) OLD POSTERIOR INFARCTION	1) CONTINUED PROGRESSION OF GANGRENE IN FOOT. AK AMPUTATION REQUIRED ON 10TH POSTOPERATIVE DAY. VEIN GRAFT POTENT.
B. U. H. AGE 53 (M) ARTERY HOMOGRAFT	INTERMITTENT CLAUDICATION	HYPERTENSION	ASYMPTOMATIC 24 MONTHS.
J. U. H. AGE 65 (M) TEFLON GRAFT	1) INTERMITTENT CLAUDICATION 2) REST PAIN 3) GANGRENOUS FIRST TOE	1) HYPERTENSION 2) OLD POSTERIOR WALL MYOCARDIAL INFARCTION	1) ASYMPTOMATIC 8 MONTHS. 2) GANGRENOUS TOE AMPUTATED AND SITE HEALED.
W. B. AGE 63 (M) AUTOGENOUS VEIN GRAFT	1) INTERMITTENT CLAUDICATION 2) REST PAINS	HYPERTENSION	ASYMPTOMATIC 7 MONTHS

Fig. 3—The number of cases of superficial femoral artery occlusion treated by direct surgery (continued on next page).

Fig. 3 (continued)

OPERATIVE FINDING AND TREATMENT	CHIEF COMPLAINT	ASSOCIATED DISEASES	RESULTS
M. F. AGE 60 (F) AUTOGENOUS VEIN GRAFT	INTERMITTENT CLAUDICATION	1) BILATERAL INTERMITTENT CLAUDICATION. 2) OLD POSTERIOR WALL MYOCARDIAL INFARCT.	1) ASYMPTOMATIC FOR ONE YEAR; OCCLUSION AT THIS TIME, HOWEVER, SYMPTOMS NOT AS SEVERE AS BEFORE OPERATION.
M. S. AGE 63 (F) ARTERY HOMOGRAFT	1) INTERMITTENT CLAUDICATION 2) REST PAIN	1) HYPERTENSION 2) OLD POSTERIOR WALL MYOCARDIAL INFARCTION	1) ASYMPTOMATIC 2) PATIENT DIED OF A CEREBRAL VASCULAR ACCIDENT WITHIN 1 MONTH OF HER OPERATION.
M. H. AGE 52 (M) THROMBOENDARTERECTOMY	INTERMITTENT CLAUDICATION	BILATERAL INTERMITTENT CLAUDICATION	OCCLUDED ON 7TH POSTOPERATIVE DAY AND AMPUTATION REQUIRED.
E. B. AGE 62 (M) TEFLON GRAFT	1) INTERMITTENT CLAUDICATION 2) REST PAIN	1) HYPERTENSION 2) AURICULAR FIBRILLATION	1) OCCLUDED IN 4 MOS. 2) SYMPTOMS NOT AS SEVERE AS BEFORE OPERATION.
V. C. AGE 58 (M) TEFLON GRAFT	INTERMITTENT CLAUDICATION	1) OLD POSTERIOR WALL MYOCARDIAL INFARCTION	1) OCCLUDED IN 6 MOS. RE-OPERATION AND GRAFT REOCCLUDED 4 MONTHS LATER. 2) ISCHEMIC SYMPTOMS THE SAME BEFORE OPERATION.

One iliofemoral artery homograft occluded after six months and at reoperation the graft had dilated to twice its original size. A Teflon prosthesis was inserted in its place with restoration of blood flow; this patient has had complete relief of symptoms for one year. One patient of special interest had a complete occlusion of the iliofemoral and superficial femoral artery down to the adductor canal; in addition, a painful foot ulcer was also present. A Nylon graft was inserted from the common iliac artery to the popliteal artery; the patient has had healing of his ulcer and is living and well 19 months later.

In the superficial femoral artery occlusion group, where a femoral popliteal artery bypass graft or a thromboendarterectomy was employed, the results were far from satisfactory. Of the 11 patients, only 3 can be classified as having excellent results in that complete relief of intermittent claudication and return of peripheral pulses have remained during their follow-up study. As noted in Figure 3, one patient with a homograft has been followed for two years with relief of symptoms; however, the graft is enlarging and he will undoubtedly require reoperation in the future. Two other patients have been followed for less than a year, one with Teflon cloth prosthesis and the other with an autogenous vein graft and both are asymptomatic. In 5 other cases where an artery homograft or cloth prosthesis was employed, occlusion occurred within a year following operation. In one patient two prostheses have been used and both have occluded; the first six months postoperative, the second four months later. It was observed however, that each of these patients was relieved of his ischemic symptoms for the period of time the graft was patent, and when present, amputated gangrenous toe sites and foot ulcers healed. Furthermore, when the grafts did occlude, the ischemic symptoms did not appear to be as severe as they were prior to surgery. In 3 patients amputation was required during the immediate postoperative period; in one patient a homograft became infected and amputation was necessary on the seventh postoperative day; in another patient, a superficial femoral artery obstruction, treated by thromboendarterectomy, occluded on the eighth postoperative day; and in the other a 78-year-old male with a gangrenous foot required a mid-thigh amputation, although at the time of amputation the autogenous vein graft was patent. Two of these three patients had severe arteriosclerotic involvement of their extremities and by present day standards would not be considered as candidates for a grafting procedure.

COMMENT: The many factors responsible for the failure of the reconstructive procedures in the aorto-iliac, iliofemoral and superficial femoral arteries have been discussed by a number of surgeons in recent surgical literature. In general, continued progression of the arteriosclerosis, abnormal host reaction to the graft employed, and technical errors at the time of surgery have been emphasized. In this series it was quite apparent that when these arterial reconstructive procedures were employed to replace the aorta and the iliac arteries, the duration of patency was far superior to the same procedure when it was used in the smaller superficial femoral and popliteal arteries.

With respect to the type of arterial reconstructive procedure to be employed, this series is too small to make any definite statements. However, thromboendarterectomy when used to establish arterial continuity in the aorto-iliac area proved most satisfactory when the condition of the artery wall permitted its use. The use of cloth prostheses as artery replacements, namely Nylon, Dacron, and Teflon, also proved satisfactory, although each had their limitations; Teflon was preferred in most cases as blood loss through the interstices was minimal; Dacron on the other hand was technically the easiest of the prostheses to work with, however excessive blood loss was encountered during the first few minutes following re-establishment of blood flow. Autogenous vein grafts, although employed in only 3 patients, proved most satisfactory as bypass grafts in the femoral-popliteal area. Homologous artery grafts have fallen into disrepute and therefore were not used during the last 18 months of this series.

For the present the selection of patients for these procedures remains indeterminant. From this study it would appear that in patients with aorto-iliac and iliofemoral artery obstruction satisfactory results may be expected for a period of one to two years. What the long-term results will be remains to be seen. Recently, DeBakey[4] has reported excellent results in some 500 patients over a period of three years. Despite the high incidence of early occlusion in the superficial femoral-popliteal artery group, these procedures are still advisable for patients severely disabled by ischemic symptoms. When they are employed for the sole purpose of relieving intermittent claudication, the end results are discouraging.

Summary

A follow-up study of 31 arterial reconstructive procedures is reported. Symptomatic infrarenal abdominal aortic aneurysms are a threat to life and are a definite indication for excision and grafting procedure. The indications for arterial reconstruction in aorto-iliac and iliofemoral artery obstruction are less specific. However, good results may be expected in 90% of the patients in whom they are employed. When these same procedures are used in superficial femoral artery obstruction, a high percentage of late closures occur during the first postoperative year. Because of this finding, arterial reconstruction in this area should be considered more as a palliative procedure to be used in the treatment of the general problem of arteriosclerosis.

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ACKNOWLEDGMENT: I wish to acknowledge the assistance of the members of the Department of Medicine and Anesthesiology, Frederic E. Mohs, M.D., Department of Chemosurgery and William P. Young, M.D., Department of Surgery, in the management of these patients.

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one of a series

Medical Stamps

GALILEO
GALILEI
(1564–1642)

A native of Pisa, where he studied medicine. Best known for his work on gravitation and the measurement of time. He is also famous for his original work on the compass and the telescope. Italy shows him on stamps #D16, D18, 419, 422. Above is #D16.

RENE
THEOPHILE
HYACINTHE
LAENNEC
(1781–1826)

He was a native of Brittany and a regimental surgeon. He was one of the most distinguished of France's internists and world famous for his invention of the stethoscope in 1819. He was a victim of phthisis. He was never honored on a postage stamp until recently. France #685. He is shown on a French tuberculosis seal issued in 1926, and on a Christmas seal of the U.S. issued in 1938.

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one of a series

ROENTGEN RIDDLE . . .

HISTORY: A 77-year-old, foreign-born, diabetic, white female experienced one episode of vomiting and then severe right upper quadrant abdominal pain, with radiation to the back of 24 hours duration.

PHYSICAL EXAMINATION: There was right upper quadrant tenderness with rebound. The bowel sounds were decreased, and no masses were palpable.

LABORATORY: White blood cell count: 26,100. Routine urinalysis revealed 4 plus albumin and 15 to 25 white blood cells per high power field.

X-RAY: The plain film of the abdomen revealed a large radiolucency with a smooth outline. Surrounding this area was a concentric ring of small radiolucencies or bubbles.

Prepared by Alphonse Richter, M.D., resident in radiology at Milwaukee County Hospital, under direction of John R. Amberg, M.D., radiologist, Department of Radiology at Milwaukee County Hospital.

SEE DISCUSSION ON PAGE 200

Sponsored by Section on Pathology
State Medical Society of Wisconsin

CLINICOPATHOLOGIC CONFERENCE

Guest Editor: D. MURRAY ANGEVINE, M. D.
Madison, Wisconsin

CASE PRESENTATION*

This was the fifth hospital admission of this married white female, age 61, who was referred from a county hospital because of spiking fever of one week's duration.

The patient was first admitted to this hospital in June, 1955, because of marked anemia and mild cardiac decompensation. Diagnoses of pernicious anemia, diabetes mellitus, and mitral stenosis due to rheumatic heart disease were made at that time. She responded well to vitamin B_{12}, 60 mcg. monthly, 0.2 mg. of digitoxin daily and a low sodium 1,000-calorie diet. Her mild diabetes required no insulin. The patient was re-admitted in September, 1955, and had been doing well on the above regimen. She remained markedly obese, however, despite instructions for calorie restriction.

In February, 1958, she was admitted for a mild episode of viral hepatitis; liver function tests were normal at the time of discharge. She was advised to continue with digitoxin and salt restriction for her heart disease, diet therapy, and 45 units of NPH insulin for her diabetes.

On Sept. 18, 1959, she became febrile, suddenly semicomatose and unresponsive. On Sept. 19, she was admitted to the hospital in a semicomatose state. She complained of nausea, vomiting, intermittent epigastric pain, urinary frequency and nocturia of two weeks' duration. She had received sulfisoxazole (Gantrisin) without benefit.

Her blood pressure was 180/90, pulse 120 (regular), temperature 104 F. rectally. The eyes deviated to the right. There was no nuchal rigidity or venous distention. The lungs were clear to percussion and auscultation. The heart was believed to be enlarged, with the left border being percussed 10 cm. to the left of the midsternal line. An opening snap was heard over the mitral area. The mitral first sound was very loud and snapping. A rumbling Grade 3 presystolic murmur and a soft systolic murmur were noted in the mitral area. The liver was palpated 5 cm. below the right costal margin. Flaccid paralysis of the left arm and leg was noted. The initial laboratory work revealed a 0.03% albuminuria, glucosuria of 4+, and 6 white blood cells per high-power field on the centrifuged urine specimen. The hemoglobin was 16.2 gm./100 ml., the white blood cell count was 23,530 with segmented cells 91%, band forms 2%, lymphocytes 6%, monocytes 1%.

Admission blood chemistries were as follows: fasting sugar 350 mg./100 ml., blood urea nitrogen 43 mg./100 ml., carbon dioxide 27 mEq./l., chloride 96 mEq./l., sodium 146 mEq./l. and potassium 4.3 mEq./l. A spinal puncture revealed normal pressure and dynamics, with 29 polymorphonuclear leukocytes and 21 red blood cells, protein 20 mg./100 ml. negative culture and Gram's stain.

A bedside chest x-ray revealed no change from the previous admission and indicated a normal size heart and clear lung fields. The electrocardiogram showed nonspecific RS-T segment depression. The patient was treated with intravenous fluids, regular insulin according to degree of glycosuria, 0.2 mg. digitoxin daily and chloramphenicol 500 mg. each six hours intramuscularly. The urine culture on Sept. 19 revealed no growth but the blood culture on admission grew coli aerogenes. A subsequent urine culture on Oct. 2 revealed coli aerogenes. On Sept 22, 1959, chloramphenicol was increased to 4 gm. per day.

The patient's clinical status improved slowly with progressive return of consciousness and orientation. She continued, however, to have a high spiking fever with temperatures to 103 F. for nine days following admission. With adequate hydration the blood urea nitrogen fell to 18 mg./100 ml. on Sept. 21, 1959, and remained normal. The liver function tests revealed an alkaline phosphatase of 11.2 King Armstrong units, a total bilirubin of 0.2 mg.% and a direct bilirubin of 0.1 and a 2+ Hanger's test. Serum albumin was 3.2 gm.% and globulin 2.8 gm.%. The prothrombin time was 100%. Multiple stool guaiac tests were negative. The white blood cell count on Sept. 21, 1959, was 11,150 and remained in this range throughout the rest of her admission. Urinalysis revealed 15 white blood cells per high-power field in a centrifuged specimen.

The patient's diabetes was easily controlled with small doses of insulin and eventually she was given 250 mg. chlorpropamide (Diabinese) daily. Her blood pressure was elevated in the range of 210/110 during her hospital stay. The patient maintained a low grade fever from Sept. 29 through Oct. 8 with daily elevations to 100 F. and remained afebrile

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from Oct. 8, 1959, to the time of her discharge on Oct. 20, 1959. The patient's sensorium continued to improve and she was able to take adequate nourishment orally, although she continued to demonstrate a complete left-sided hemiplegia. A chest x-ray on Oct. 4, 1959, demonstrated blunting of the left costophrenic angle. Repeated urine and blood cultures were negative after the chloramphenicol was discontinued on Oct. 10, 1959. White blood cell count on Oct. 21, 1959, was 12,300. The patient was discharged Oct. 20, 1959, to a county home on chlorpropamide 250 mg. per day; digitoxin 0.1 mg. per day; a 1,200 calorie, 800 mg. sodium diet; vitamin B_{12}, 50 mcg. each month; and reserpine 0.25 mg. each day.

The patient was re-admitted from the county home on Nov. 11, 1959, in a stuporous state. She had apparently been doing fairly well until one week prior to admission when she developed dysuria, frequency, right upper quadrant pain and fever. She had received chloramphenicol 2 gm. daily since Nov. 6. She was thought to be transiently jaundiced two days prior to admission. On physical examination the patient had a blood pressure of 130/70, pulse of 110, respirations 20, and temperature of 99.4 F. The optic fundi showed moderate arterial spasm. The neck veins were not distended. A few moist rales were heard at both lung bases posteriorly. The heart was enlarged to the anterior axillary line and a Grade 2, rumbling, presystolic crescendo murmur was heard at the mitral area and also a Grade 2 systolic murmur was heard at the apex. The liver was palpable 6 cm. below the right costal margin and was smooth. No other organs or masses were felt. The neurologic examination again demonstrated the left-sided hemiplegia. There was moderate right costovertebral angle tenderness. The urine specific gravity was 1.006; it contained 0.1% albumin, 5 white blood cells and 1 red blood cell in a noncentrifuged specimen. The hemoglobin was 11.3 gm./100 ml., the reticulocyte count 0.1%, and the indices were normal. The white blood cell count was 25,300 with 80% segmented cells, 14% band forms, 5.5% lymphocytes. Blood sugar was 80 mg./100 ml., blood urea nitrogen 71 mg./100 ml., alkaline phosphatase 31.5 King Armstrong units, and a total bilirubin 1.1 mg./100 ml. direct reacting of 0.5. The serum albumin was 3.0 gm.%, and globulin 3.0 gm.%. Urine and blood cultures were obtained and the patient was given chloramphenicol and intravenous fluids. She continued to do poorly with a spiking febrile course with temperatures to 105 F. A left-sided pleural effusion was tapped on Nov. 16 and 200 cc. of straw-colored fluid obtained. The fluid clotted spontaneously and contained 1 gm.% protein, many red blood cells and 4 white blood cells per high-power field. On Nov. 12, 1959, coli aerogenes was isolated from the admission blood cultures and on Nov. 16, 1959, alpha hemolytic streptococcus was reported. Ten million units of penicillin and 2 gm. of streptomycin daily were started on Nov. 16, 1959. The white blood cell count on Nov. 16, 1959, was 33,000, the blood urea nitrogen 77 mg./100 ml., and the thymol turbidity 3.5. The patient's clinical condition continued to deteriorate and she became increasingly comatose with temperatures to 105 F.; she died on Nov. 17, 1959.

Doctor Moore was the visiting professor of the week. He is Busch Professor of Medicine and Chairman of the Department, Washington University School of Medicine, St. Louis, Missouri.

Discussion

Dr. Carl Moore: This lady had apparently learned to live reasonably well with the three diseases we know she had: pernicious anemia, diabetes mellitus, and rheumatic heart disease. The pernicious anemia had been well treated, and the diabetes was not difficult to control. Early in September, 1959, she complained of nausea and vomiting, intermittent epigastric pain, urinary frequency and nocturia, and possibly had a low grade fever. Suddenly on September 18 she became semicomatose. When admitted to the hospital the next day, she was found to have the murmurs of mitral stenosis and insufficiency, hepatomegaly, and left-sided hemiplegia. The white blood cell count was elevated to 23,000, mature and band neutrophilic leukocytes totalled more than 90%; urine contained a moderate amount of protein, 4+ glycosuria, and probably a slightly greater than normal number of white blood cells. The spinal fluid was clear, the pressure and protein content were not increased, but there were 29 segmented leukocytes and 21 red blood cells per cu. mm.; no organisms were identified by culture or microscopic examination. The blood culture was positive for coli aerogenes, and therapy with chloramphenicol was started, presumably because the organism was shown to be sensitive to that antibiotic.

Several diagnoses can be made with reasonable confidence:

1. *Rheumatic heart disease,* mitral stenosis and insufficiency. Lesions other than rheumatic heart disease which caused the murmur of mitral stenosis would hardly have been present since 1955; namely, vegetations on the mitral valve, dilatation of the left ventricle, aortic insufficiency producing an Austin Flint murmur.
2. Bacterial endocarditis involving the diseased mitral valve. The designations acute or subacute are less important than identification of the infesting agent as a coliform organism. We are

not told whether the Bacillus was Escherichia coli or Aerobacter aerogenes, but that differentiation is of less importance than is determination of sensitivity to antibiotics. It is difficult to date the onset of bacterial endocarditis in older patients because they notoriously may have the disease for a period of time with minimal symptoms.

3. *Cerebral embolus* to the right middle cerebral or anterior cerebral artery. Differentiation between these two possible sites is not possible, but the former is the more likely since the paralysis involved the upper extremity as completely as the lower, and statistically is the more common site. Cerebral thrombosis or hemorrhage seems less likely than a cerebral embolus in a patient with bacterial endocarditis. The spinal fluid contained no blood, furthermore, and was not under increased pressure. The moderate pleocytosis is consistent with a cerebral embolus, particularly a septic embolus. Lastly, the leukocytosis of 23,000 cells would be compatible with an embolus; leukocyte counts above 15,000 per cu. mm. are unusual in uncomplicated bacterial endocarditis.
4. *Chronic pyelonephritis* was probably the source of the coliform organism. The fact that the initial urine culture was negative is a little disturbing, but a positive culture is by no means always obtained and growth of the organism may have been temporarily suppressed by the sulfisoxazole therapy. The manifestations of chronic pyelonephritis were admittedly minimal (frequency, nocturia, and only minimal pyuria), but that is not unusual. The incidence of chronic pyelonephritis in diabetic patients on whom autopsies are done has been reported to be as high as 20% or more.

   Beeson and Rowley (J. Exp. Med. *110:* 685, 1959) have recently offered an intriguing explanation for the peculiar vulnerability of the kidney to coliform bacterial infection. It has always been difficult to understand why coliform organisms so frequently cause infections of the genitourinary tract, yet are only rarely solely responsible for disease of other organs. In animal experiments, furthermore, the renal medulla seems more susceptible to infection with E. coli than does the cortical area. Beeson and Rowley, in a brilliantly conceived series of experiments, first demonstrated that kidney homogenates interfere with the ability of normal serum to destroy coliform bacteria; similar homogenates of liver, spleen, lung and muscle had little or no effect on the bactericidal action of normal serum on these organisms. They then obtained evidence that the effect of kidney homogenates in their test system could be attributed to a strong anticomplementary activity of kidney, 5 to 15 times greater than that of other organs. The inactivation of complement by kidney tissue had the characteristics of a chemical reaction; the C'4 component of complement was the one inactivated. This observation was of particular interest since the C'4 component is particularly susceptible to injury by ammonia, and ammonia is formed in the kidney, particularly in the medullary portion. The reactions which tended to enhance ammonia formation by kidney homogenates also tended to increase the inactivation of complement. The authors are careful and conservative in the conclusions they make, but their observations provide a possible explanation for the fact that coliform bacteria are a very frequent cause of chronic pyelonephritis.
5. A diagnosis of hypertension can also be made. Hypertension occurs in about 25% of all patients with chronic pyelonephritis; the incidence rises to 50% when renal function has been impaired. The evidence for decreased renal function in this patient is equivocal since the blood urea nitrogen returned to normal after the fluid deficit had been corrected.

The patient was well managed clinically and improved slowly but steadily. Chloramphenicol was administered for three weeks, from Sept. 19 to Oct. 10. The blood culture was negative at the end of this treatment period, but usually one would have preferred to continue antibiotic therapy for a total of six to eight weeks, particularly when the endocarditis is caused by coliform bacteria. There are two disturbing things about her

condition at the time she was discharged from the hospital: the blunting of the left costovertebral angle on the chest roentgenogram, and the persistent leukocytosis.

Doctor Meyer, this would be an appropriate time to interrupt the discussion and to ask that the various roentgenograms be presented.

Dr. Andrew B. Crummy, Jr.: Films are available dating from the patient's first admission in May, 1955.

The chest films (May 31, 1955) show questionable widening of the cardiac shadow in its transverse portion. The left ventricle is somewhat prominent as is the aortic knob. An apical fat pad as well as one at the right cardiophrenic angle are seen in the posteroanterior projection. The trunk shadows in the medial bases are slightly increased but there is no evidence of pulmonary congestion. A few strands of lobular atelectasis are seen in the left base.

A gastrointestinal series (June 6, 1955) was done and the esophagus, stomach, and duodenum were normal.

Posteroanterior and lateral chest films (Feb. 12, 1958) show a decrease in heart size when compared with the examination in 1955, and it is now within normal limits. The cardiophrenic fat pads are no longer noted. The diaphragmatic domes are at a normal level and the costophrenic sulci are clear. The accentuation of the basilar trunk markings previously seen is not evident in this study and the lung fields are clear.

A bedside chest film (Oct. 5, 1959) shows the chest in incomplete inspiration. The main pulmonary artery segment shows increased convexity. The hilar and immediate perihilar areas show hazy density suggesting moderate pulmonary congestion and/or edema. The lateral left hemidiaphragm is not well delineated and there is obliteration of the sulcus suggestive of fluid.

A bedside film of the abdomen taken at the same time shows the tip of the spleen at the level of the lateral extremity of the left eleventh rib and it is believed to be rather generous in size. The left hemidiaphragm is not well outlined. The cardiac size (Nov. 12, 1959) is unchanged since the last examination. There is a hazy density obliterating the costophrenic sulcus on the left and slight blurring of the lower third of the lung. The dome of the left hemidiaphragm cannot be seen. The hilar areas and the vascular channels radiating from them are again prominent and pulmonary edema and congestion is believed to have increased slightly. The right diaphragmatic dome is smooth and the sulcus is clear.

Doctor Moore: After the patient was discharged from the hospital, she did well for about two weeks, but then developed dysuria, frequency, right upper quadrant pain, fever, and possibly transient jaundice. The resident who cared for her tells me that her stupor came on gradually. When she was admitted the last time, her blood pressure was within normal range; there were signs of a left pleural effusion, hepatomegaly was still present, and the signs of left-sided hemiplegia had persisted. It is comforting to know that the roentgenograms showed her spleen to be somewhat enlarged even though it could not be felt, since both bacterial endocarditis and pyelonephritis tend to cause splenomegaly. The white blood cell count was now 25,000 per cu. mm. Urine specific gravity was only 1.006; a few white and red blood cells were seen when the uncentrifuged urine was examined microscopically. The blood urea nitrogen, alkaline phosphatase, and serum bilirubin values had all increased.

Both coli aerogenes and alpha hemolytic streptococcus were grown on culture of her blood; consequently we are justified in saying that she had a recurrence of the bacterial endocarditis or that it had never been cured in the first place; the disease now probably involved both organisms. Mixed infections causing bacterial endocarditis have been reported on a number of occasions, but I am unaware of any instances involving these two organisms.

Recurrence of urinary symptoms, including right upper quadrant pain, makes it necessary to ask whether another renal lesion had been added. Necrotizing papillitis seems unlikely since the pain was not colicky in type, oliguria was at least not conspicuous and the blood urea nitrogen was probably not rising rapidly. The renal lesions most commonly associated with bacterial endocarditis are embolic glomerulonephritis, diffuse glomerulonephritis, and renal infarction. The changes in the urinary sediment were not striking enough to suggest the last two of these three possibilities; embolic glomerulonephritis may have been present.

A number of things, however, need to be explained: the stupor, the left pleural effu-

sion, hepatomegaly, the increased alkaline phosphatase and serum bilirubin, and the leukocytosis which reached a level of 30,000. Older people with fever and a severe infection may, of course, become stuporous; but the temperature elevation was hardly enough to have, by itself, caused this change. The pleural fluid at first glance may have been explained on the basis of cardiac failure, pulmonary infarction, or empyema. There was no real evidence for infarction or heart failure; however, the pleural fluid was sterile with a somewhat high protein content. One must think, therefore, of the possibility that the pleural effusion might be a reaction to a lesion below the left diaphragm, particularly because splenic abscess may occasionally be found in patients with coliform endocarditis. The coliform bacteria are pyogenic so abscesses may have developed in various areas of the body, as for instance in the brain at the site of the earlier cerebral embolus. If such abscesses form, they could explain the stupor, the leukocytosis, and the left pleural effusion. Liver abscess in coliform septicemia must be very rare; I am unable to provide a satisfactory explanation for the elevated alkaline phosphatase, the increased serum bilirubin, and the hepatomegaly unless they were caused by hepatic congestion.

Clinical Diagnoses:

1. Rheumatic heart disease, mitral stenosis and insufficiency.
   tion).
2. Bacterial endocarditis (mixed infec-
3. Chronic pyelonephritis (? with embolic glomerulonephritis).
4. Cerebral embolus to right middle cerebral artery.
5. Hypertension.
6. ? Multiple abscesses, site undetermined.
7. Diabetes mellitus.
8. Pernicious anemia, treated.

Dr. L. I. Gottlieb: At autopsy no significant abnormalities were present upon external examination. There was 100 ml. of cloudy yellow fluid present in the left hemithorax. Areas of patchy atelectasis were evident within the left lower lobe.

The heart weighed 400 gm. The mitral valve was thick, its cusps fused, and several round soft vegetations were present on the free surface. The largest vegetation measured 1 x 0.7 x 0.5 cm. The left auricle was moderately dilated.

Fig. 1—An abscess 10 x 6 x 6 cm. bordered by the left diaphragm superiorly and posteriorly and by the spleen inferiorly and anteriorly.

An abscess, 10 x 6 x 6 cm. bordered by the left diaphragm superiorly and posteriorly and by the spleen inferiorly and anteriorly, was present. This is illustrated in Figure 1. The necrosis of splenic tissue adjacent to the abscess indicated that the abscess resulted from an infected infarct. The splenic border of the abscess displayed changes seen in infarctions.

Five abscesses, the largest measuring 2 cm. in diameter, were present within the right lobe of the liver.

Multiple nodules of fat necrosis, measuring from 1 to 5 mm. in diameter, were scattered throughout the pancreas.

The left kidney weighed 140 gm.; the right, 260 gm. Although the gross architecture of the left kidney was undistorted, that of the right was indistinct and white streaks were evident beneath the cortex.

The brain weighed 1,270 gm. Within the right cerebral hemisphere, occupying the right centrum ovale, was a well demarcated necrotic cavity about 4 cm. across, contain-

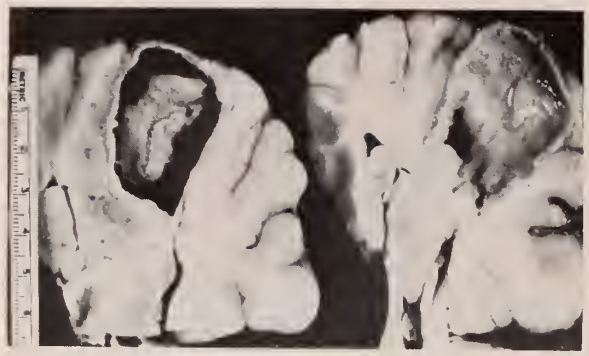

Fig. 2—A well demarcated necrotic cavity about 4 cm. across, containing pus and irregularly shaped pieces of brain tissue, located within the right cerebral hemisphere, occupying the right centrum ovale of the brain.

ing pus and irregularly shaped pieces of brain tissue; see Figure 2.

The material from the splenic, hepatic and cerebral abscesses was cultured and E. coli was isolated from each site. A section of the vegetation from the mitral valve was stained with a Gram's stain and many Gram-negative bacilli were present within the tissue. Microscopic examination confirmed the gross findings of infected infarcts of the spleen and brain. Both acute and chronic pyelonephritis were observed.

This patient with rheumatic mitral stenosis developed an acute E. coli bacterial endocarditis presumably associated with bacteremia secondary to pyelonephritis. Embolic phenomena from the vegetations were responsible for the abscesses in the spleen and brain. It is most probable that those in the liver were secondary to the infection of the spleen. As for the anatomic diagnoses, in this case they are essentially as listed in Doctor Moore's discussion so they will not be repeated.

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ROENTGEN RIDDLE continued from page 194

DISCUSSION: The findings are pathognomonic of acute emphysematous cholecystitis. This disease is being reported with increasing frequency. Clinically, the patient may be more ill than the usual acute cholecystitis and has been so for 24 to 48 hours. Interestingly, elderly males, of whom 25% are diabetics, are particularly affected. Gas-forming bacilli (Clostridium welchii predominates) are responsible for the disease.

The pathogenesis is not clear, but W. A. Wilson theorizes that the disease is an extension of the usual form of acute cholecystitis. The sequence might be a decreased arterial supply to the mucosa of the gallbladder secondary to the inflammation and edema with resultant anoxemia or even necrosis. This creates an ideal environment for the anaerobes which may be present in the biliary tree. That the disease may be secondary to the usual forms of cholecystitis is supported by the fact that air in the gallbladder or pericholecystic tissue has not been seen in patients who have not had symptoms for at least 24 to 48 hours. Biliary stones are seen in approximately 87% of the cases.

The differential diagnosis of air within the biliary tree is not too difficult. There are four ways, including anaerobic infection, in which air gains access to the biliary system. Reflux of air within the duodenum through an incompetent sphincter of Odii has been described. The surgeon who performs a cholecysto-enterostomy, for whatever reason, produces a situation for air to enter the biliary tree. Pathologically, again, are the spontaneous fistulas, whether secondary to peptic ulcer, eroding gallstones, or, more rarely, eroding carcinomas of the colon. These acute spontaneous fistulas usually reveal a small or normal size gallbladder and no air-fluid level or interstitial emphysema. Contrast examination of the upper and lower intestinal tracts will generally solve the problem as to the source of air within the biliary tree.

TREATMENT: Depending on the source, surgical or conservative treatment is recommended. Proponents of surgery caution against the spontaneous perforation of the distended gallbladder with its disastrous sequelae of fulminating bile peritonitis. Their point is well taken. The antibiotic and supportive therapy group point to mortality statistics which apparently are higher in the operative cases.

We Can Do More Than Talk About Accidents

By LUIDA E. SANDERS, M.A.

Madison, Wisconsin

IT IS AN OLD CLICHE that everyone talks about the weather—but does nothing. From one point of view at least, this was never strictly true. We do read the thermometer and comment on what we see. And some of us make big, beautiful tables and charts of the results. We also put on more clothes—or take them off, build warmer or cooler houses, and complain bitterly when a sudden shower cancels the ball game. But basically we do nothing about controlling the weather.

Many people feel that you can substitute the word "accidents" for the word "weather" and still have a true statement. Up to a point they may be right. All of us do talk about accidents. Many statistics are collected about who was injured or died, how old they were, when and where the accident happened. Even much of the present accident prevention activities are comparable to our putting on or taking off clothes to adapt to the weather. For example, engineers are building safety into cars with the recessed steering column, padded dash, and seat belts. Electrical appliances must meet standards of safety before they can be sold. Fire departments maintain highly efficient alarm systems and practice effective ways to put out fires.

Yet almost every newspaper tells gruesome stories of murder on the highway, electrocution at home, or fiery death in public and private buildings. Why? Some people will say because accidents will happen, it is just fate, or everyone has his share of bad luck.

At this point the comparison of accidents and the weather is no longer valid. We can do a great deal about preventing accidents just by using present knowledge, and we can assuredly do more in years to come by following up some of the promising leads researchers are discovering. Recent estimates of this potential range from 70 to 80%.

Miss Sanders is Director, Division of Health Education, State Board of Health, Madison.

Safety work in the industrial and highway fields is evidence that the "three E's"—engineering, enforcement, and education—can cut the number of accidents substantially when everyone involved cooperates. The problem is how to develop such attitudes toward safety in people that they will not take risks or otherwise behave in an unsafe way. A number of studies suggest that persons who have repeated motor vehicle and industrial accidents also have difficulties in other personal and social aspects of their lives. Temporary emotional states appear to be a contributing cause. How to apply these understandings to accident prevention along with the time-tested methods awaits further study; however, the use of discussion groups offers some promising possibilities as does individualized counseling which might be done in the physician's office.

Engineering and enforcement are of more limited use in the prevention of home and public accidents than in industrial and highway ones. Take poisoning in children for an example. Engineering can design a medicine cabinet that locks or a tamper-proof bottle cap. Laws can require labeling of poisons and control sales. But education is the only tool to help parents take advantage of these things, and at best it can reach only those who will listen.

The increasing number of poison control and poison treatment centers in the hospitals throughout the state provides an opportunity for research into this problem. If enough cases both serious and near-misses can be studied in depth, perhaps someone can find answers to why parents do not listen, or listening do not act to keep their children from the danger of death by poisoning or answers to why children go back again and again. From these answers we might devise ways to help parents and children to live safely in this increasingly complex world. Such lessons could reasonably be extended to most other aspects of safety as well.

There are great gaps in our knowledge not only about mental and emotional aspects of accident prevention but also in the more obvious relationship of accidents to physical condition and how one can compensate for disability, of the effects of various drugs, the hazards peculiar to age or sex, the limits of physical capability for driving or handling certain high-risk jobs, among others. Research is presently under way or planned in many of these areas and more is needed.

Even more pressing is the problem of how to apply the results of this research in day-to-day work so that control of accidents which are a major cause of death and disability may come closer to realization. It is in this area that the physician has a unique opportunity to carry out indoctrination in safety measures and principles and can evaluate how new technical information can be applied to individuals.

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MATERNAL MORTALITY INSTITUTE

St. Mary's Hospital, Wausau, Wednesday, May 24, 1961

For: Physicians, Hospital Administrators, OB Nurses, Supervisors, and Nurse Anesthetists.

No Registration Fee: Costs underwritten by State Board of Health and State Medical Society.

Moderator: A. H. Stahmer, M.D., Wausau—President-elect, Wisconsin Academy of General Practice

P.M.

2:00—SPECIAL PROBLEMS OF THE PREGNANT DIABETIC

Ben Peckham, M.D., Professor and Chairman of the Department of Obstetrics and Gynecology, University of Wisconsin Medical School

E. S. Gordon, M.D., Professor of Medicine, University of Wisconsin Medical School

3:00—BLOOD PROBLEMS OF SPECIAL SIGNIFICANCE IN PREGNANCY

Tibor J. Greenwalt, M.D., Director, Milwaukee Blood Center and Associate Professor of Medicine, Marquette University School of Medicine

P.M.

3:30—COFFEE BREAK

4:00—TRAUMA DURING DELIVERY AND ITS CONSEQUENCES

T. A. Leonard, M.D., Clinical Instructor in Obstetrics and Gynecology, University of Wisconsin Medical School

4:30—CATASTROPHIC SITUATIONS IN THE DELIVERY ROOM

William Kreul, M.D., Anesthesiologist, St. Mary's Hospital, Racine

5:00—ADJOURNMENT

Academy Credit: 3 Hours of Category I credit for all Academy members who attend.

Program Presented By: State Medical Society of Wisconsin—Wisconsin State Board of Health—Wisconsin Academy of General Practice (Wisconsin Valley Chapter)

Editors
HARRY BECKMAN, M. D., Marquette University
F. E. SHIDEMAN, M. D., University of Wisconsin

By HARRY BECKMAN, M.D.
Milwaukee, Wisconsin

Table of Antibiotic Toxicities

	GI	Renal	Blood	CNS	Fever	Hepatic	Allergic	Other
Amphotericin B (Fungizone)	nausea vomiting anorexia	reversible		headache	with chills			thrombophlebitis
Bacitracin (Baciguent)		reversible						local pain, induration
Carbomycin (Magnamycin)	(mild)							
Chloramphenicol (Chloromycetin)	nausea vomiting diarrhea stomatitis		granulocytopenia thromcytopenic purpura aplastic anemia	optic neuritis (rare)				rashes (rare)
Cycloserine (Seromycin)				tremors, convulsions, psychoses				
Erythromycin propionate lauryl sulfate (Ilosone)	nausea vomiting soft stools						urticaria(?)	
Fumagillin (Fumidil)	pain, cramps nausea vomiting diarrhea		neutropenia	headache vertigo				rashes
Griseofulvin (Fulvicin, Grifulvin)	(mild)			headache vertigo deafness			urticaria angioneurotic edema	secondary monilial lesions joint pain photosensitivity
Kanamycin (Kantrex)		reversible		headache paresthesias deafness dizziness	infrequent			rashes local irritation
Neomycin (Myciffradin, Myciguent)		consistently when injected; reversible		paresthesias deafness headache blurred vision numbness anorexia			conjunctivitis	local irritation respiratory arrest (when injected intraperitoneally)
Novobiocin (Cathomycin, Albamycin)	nausea diarrhea		purpura agranulocytosis			jaundice		rashes
Nystatin (Mycostatin)	nausea vomiting diarrhea							
Oleandomycin (Matromycin) Triacetyloleandomycin (Cyclamycin, TAO)	nausea cramps diarrhea					jaundice		rashes (rare)
Penicillin	tongue discoloration glossitis stomatitis				serum sickness-like reaction		urticaria angioneurotic edema anaphylactic shock Arthus phenomenon, asthma, etc.	rashes Herxheimer reaction contact dermatitis
Polymyxin B (Aerosporin)	nausea vomiting cramps	reversible usually		circumoral itching paresthesias vertigo	with chills and sweating		urticaria	local pain and induration rashes
Ristocetin (Spontin)	diarrhea (occasionally)		granulocytopenia thrombocytopenia (serious bleeding)		(occasionally)			rashes thrombophlebitis
Streptomycin Dihydrostreptomycin		unusual reversible	eosinophilia aplastic anemia	vertigo, ataxia, paresthesias deafness (dihydro-) curariform action	occasionally		urticaria asthma, etc.	local pain, induration contact dermatitis rashes

(continued on next page)

Table of Antibiotic Toxicities *(continued)*

	GI	Renal	Blood	CNS	Fever	Hepatic	Allergic	Other
Tetracyclines (Aureomycin, Terramycin, Declomycin, Achromycin)	beefy tongue stomatitis esophagitis nausea flatulence proctitis colitis diarrhea			lightheadedness	rare	reversible	rare	thrombophlebitis rashes (rare) photosensitivity local pain, induration
Tyrothrycin (Soluthricin)	use absolutely restricted to local applications to the skin							
Vancomycin (Vancocin)		pre-existing insufficiency may be aggravated		hearing loss	with chills		anaphylactoid reaction	rashes
Viomycin (Vinactane, Viocin)		reversible	eosinophilia	vertigo, tinnitus, hearing loss				rashes hypokalemia

PREPARATION OF MANUSCRIPTS FOR WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

Correspondence: Address all correspondence relating to publication of scientific papers to the Medical Editor.

Manuscript: Type double spaced, on 20 pound white paper, 8½ by 11, with one-inch margins at the top, bottom, and right, and 1½ inches on the left. Submit the original and two carbon copies. Use the metric system throughout. Call drugs by their generic names. The trade names can be added, in parenthesis, if they are considered important. Keep one copy of the paper.

Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

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4. Doe, J. E.: What I Know About It,
Wisconsin Med. J. 54:717–719 (Dec.) 1954.

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Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

The President's Page

TO OUR LADIES

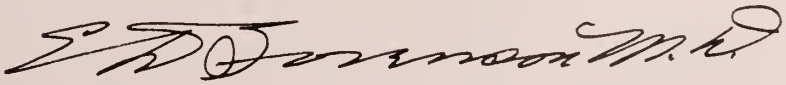
AS THE TITLE of this page tells you, you are our ladies, Ladies of the Medical Auxiliary to the State Medical Society of Wisconsin. Needless to say, but I will, we are proud of you. We are proud of you for many reasons.

First of all, you are our wives, and what could be more important than that; to us, I mean. Were it not for you, your constant care and attention, your understanding, your ability to cope with our particular idiosyncrasies, your self-sacrifice, your competence in keeping a family together, your kindly advice and reassurance in many situations; your insight and ability to diagnose our thoughts and actions before we ourselves can do so, your unfailing readiness to adjust your life to ours, and for many more reasons that I might mention, we, your husbands, with all of our dignity, and all of our beautiful bedside manners, would not have, nor could not have attained the stature that we seem to have attained in the growing and fast-moving profession to which we are dedicated. For these reasons, ladies, we are proud of you, we love you, and our only desire is that you remain with us, as you are.

Next, we are proud of you as an organization—the Auxiliary. You as a group have been and are a constant tonic to the medical profession. Through your society you have performed and promoted many worthy projects; i.e., your nurses' scholarships, your great contributions to the State Medical Society Foundation and to the American Medical Education Foundation, your assistance in the public health field and medical history, your legislative work, your work in mental health, and many other endeavors which you are constantly encouraging.

You have indeed proven that you are the A-1 medical society assistant and partner. It gives us a great deal of pleasure and comfort to know that you are with us; and believe me, we are happy to see you at all times at our combined meetings.

Lastly, we are proud of you because "you are you," and no one can take your place. Let us continue to face the future together.



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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Social Dilemma

THE MILWAUKEE JOURNAL of January 8 editorialized on the case of Terence Donovan, the Peshtigo youth who wantonly killed a 21-year-old Milwaukee girl and seriously wounded her husband. After reviewing the criminal history of Donovan, the Journal asked how it happened that Donovan was at large and free to kill. "The history of this case," concludes the Journal, "suggests that several doctors bungled badly."

Bizarre crimes, such as this one seems to be, focus attention once again on the unfortunate lag between what psychiatry and medical science could do to protect the community and what it is permitted to do under the law. The Journal is correct in its opinion that had Donovan been under periodic, competent supervision, the chances of preventing a tragedy might have been vastly improved. Unfortunately, no court can give a man an indeterminate sentence of supervision because of what he might do.

At one time in his past, Donovan was committed to Waupun central state hospital as insane. Later, he was described by competent medical authority as legally sane and not medically insane, and he was released from custody. Shortly after that he was in trouble again, convicted, sentenced, transferred to and from the central state hospital and released.

The entire pattern of this case—and it is by no means unusual in the annals of crime—reveals the sad fact that there is no legal expression of the understanding psychiatry now has of the constitutional psychopath. In our democracy we cannot try, and convict people, of what crimes they are capable of committing. Punishment, and a determination of the personal responsibility of the person adjudged, follows the act. Any interference with the freedom of an individual because he *might* commit a crime—whether it be murder, traffic rule violation or conspiracy to overthrow the government—is abhorrent to the American juridical structure. On the other hand, the community must be protected from the mentally ill who do not fit into legal definitions.

At the present time, if a person accused of a crime is considered as having no knowledge of the nature and quality of the act and of the difference between right and wrong, not in the abstract, but in the particular act, he is judged as in-

sane and committed to a mental institution. Frequently such persons are not actually insane, but constitutional psychopaths, and have no place in mental institutions. As in Donovan's case, they are soon released and free to inflict additional tragedy on society.

The psychopath can easily be identified; the problem of how and where to isolate him is a legislative one, the solution of which must come with the general advance in social development.

Terence Donovan, like many other constitutional psychopaths, is not insane, was not insane. But he is sick, and as a diseased person, he should have been isolated from society as soon as his illness was identified. It is to be hoped that the *Milwaukee Journal* will recognize that the freedom of Terence Donovan to kill results from the absence of planned social response to individual antisocial reaction. It is also to be hoped that the senseless tragedy of his crime will add incentive for the legislature to consider the problem of the psychopath and provide a practical, legal means of furnishing custodial care for the Terence Donovans to come.

Names to Remember

IT'S A PARADOX of our profession that at a time when we are vigilantly resisting the encroachment of ancillary groups and the Federal government in the practice of medicine, the American Medical Association—the very embodiment of organized medicine—has permitted itself to slough off one of its vital functions with the hope that it will be assumed by another organization.

Last May, the A.M.A. Council on Drugs announced it was requesting that the U.S. Pharmacopeia take over the responsibility of providing generic names for drugs—a responsibility which most appropriately rests with the medical profession. The critics of organized medicine were quick to misinterpret this action as evidence of a meretricious alliance of doctors and the pharmaceutical industry.

Until 1955, the A.M.A. Council on Pharmacy and Chemistry operated a laboratory for the testing of drugs, listed accepted products in its *New and Non-Official Remedies* and offered its Seal of Approval to accepted pharmaceuticals. It also emphasized the use of generic terms for drugs. In fact, the "Official Rules" of the Council pointed out that "The interests of the patient and physician are served best by adoption of an abbreviated scientific name for prescribing . . ." The following year, the Council closed its laboratory, changed its method of accepting drugs for inclusion in NNR, and dropped the Seal of Approval. This unfortunate decision was motivated largely by the tremendous expansion of the pharmaceutical industry following the second world war, overwhelming the testing laboratory to the extent that either drastic expansion or cessation became necessary. Legal implications of the Federal anti-trust laws generated additional concern at the time.

In 1959 the Reference Committee on Insurance and Medical Services of the A.M.A. recommended that "Physicians might well have consideration to prescribing by generic rather than trade names . . . in the treatment of welfare patients." But who established generic names? Who had the function of coining simple, usable names for drugs? After the abdication of this duty by the Council on Pharmacy, a decisive share of the task fell to the manufacturers of pharmaceuticals, the very groups that stand to profit by the sale of their trade-marked products.

No doctor is unaware of the advantages of prescribing drugs by their generic names. The savings to the government have been demonstrated repeatedly by public welfare institutions that demand prescriptions be in generic names whenever possible, when correlated with a system of purchasing and cost controls. The drug industry itself could do much to correct the impression created by the testimony before the Kefauver committee if it took an attitude of interest in reducing the cost of sickness to the patient. And the medical profession could certainly profit by a stand in favor of lower health care costs.

For all these reasons, and for moral and ethical considerations, we urge the A.M.A. Council on Drugs to continue responsibility for promoting the use of generic names in prescribing medicines. We urge it to accept the duty of establishing generic names, keeping them simple, usable, and free from the manipulation of interested parties. We further urge the A.M.A. to supervise the clinical evaluation of new drug performance

—the critical unmet scientific need in this era of the "miracle drugs."

If the medical profession demands respect for its integrity, its principal organization is going to have to work for that respect. The A.M.A. cannot appear to be a party to a sell-out to the drug manufacturers. Nor can the A.M.A. expect the government to assume the functions of which it has divested itself without giving the impression that the government has a legitimate regulatory role in private practice.

Drugs are an integral part of the practice of medicine. Organized medicine has a prime supervisory responsibility for helping to maintain their high quality as well as low cost. The A.M.A. can't shun this responsibility with impunity.

Medical Leadership in Rehabilitation

Reprinted with permission from the *New York State Journal of Medicine*, April 15, 1960.

THE REHABILITATION of the handicapped person to his maximum capacity for functional, social, and economic independence may require a coordinated process in which several professional groups participate. Some patients need only single services, such as physical or occupational therapy. Others require a comprehensive procedure beginning with a complete medical appraisal of the mental and physical status and including an analysis of the social background and the motivational factors and a vocational evaluation of employment potentials and capacity for retraining.

Whether simple or complex, rehabilitation begins with medical care, preferably concurrent with the latter rather than subsequent to it. Certainly, the physician is not the sole determinator of the full potentialities of the patient and he must rely upon the social workers, the therapists, and the vocational rehabilitation counselors for their professional contributions. The physician is responsible for determining the level of mental and physical improvement the patient is likely to reach, the intensity of medical and other services the patient is capable of accepting, and the time such services should begin. Likewise, it is his responsibility to the patient, throughout the entire rehabilitation procedure, to be certain that the latter's health status is maintained at an optimal level.

These medical functions are shared by all physicians, regardless of specialty, who care for patients with any disease or disorder which may leave a residual disability. Responsibility cannot be left for the very small number of physicians who have chosen physical medicine and rehabilitation as a specialty and have received board certification in this field as a mark of their exceptional professional competence. To this group must be assigned the responsibilities for the management of very difficult cases, for the organization of special rehabilitation services, and for providing consultation to other physicians as necessary.

Unfortunately, there are many physicians who have not taken an interest in or accepted responsibility in regard to the rehabilitation aspects of their patient's medical problem. As a result, complaints of the following types are often made by nonmedical agencies administering rehabilitation programs, such as vocational rehabilitation, sheltered workshops, or welfare medical care (Aid-to-the-Disabled):

1. Physicians frequently fail, either deliberately or by just not getting around to doing it, to provide the necessary medical information to assist the agency in determining the eligibility of the patient for the rehabilitation program.

2. Physicians often write down, "totally disabled," without reporting any clinical findings to back up such a statement.

3. When adequate clinical reports are submitted, physicians too often state that no rehabilitation services are indicated, when it is known by both medical and nonmedical members of rehabilitation teams that patients with similar types of handicap often show good responses to rehabilitation.

4. It is recognized that rehabilitation services are not adequate in many areas of the State. Yet several of the existing high quality facilities are having administrative and financial difficulties because they are not receiving sufficient referrals from the physicians in the community. On the basis of numerous studies of the prevalence of disabilities in a community, it appears that there are many patients just not being referred for available services.

5. When patients are referred, the physician's request is often made for a single service, such as physical therapy or occupational therapy, when it is obvious to those experienced in rehabilitation that the person requires a comprehensive evaluation. Such persons often have problems in adjusting to their disabilities, which may be interpersonal or may relate to their dealings with their family or their community. On the other hand, it may be necessary for them to have a complete change in work habits or be trained for a new vocational field because the disability prevents them from returning to their former area of occupation. Thus, rather than a few physical therapy treatments a week, they should have a social evaluation and a prevocational counseling and testing service to be followed by actual vocational training if indicated. All of these services should be begun at the earliest possible time.

6. Physicians rarely consider the current labor market or the types of jobs available in the community when recommending handicapped patients for certain jobs. The most common complaint by employment specialists is that physicians state that the patient is suitable for "light work," without having any idea of what "light work" involves. The classic example is the referral of a patient for a position as night watchman, when it is well known that the watchman must make rounds through a multistoried building every hour and be ready to take quick action in case of fire or intruders.

Related to this lack of medical leadership is the frequent tendency of many nonmedical agencies to take for granted that they are the leaders in the rehabilitation field and that physicians play a very secondary role, simply a source for which medical services may be purchased. This seems to reach a peak in the current Federal legislative proposal for a Federal program for "Independent Living Rehabilitation" (primarily a medical rehabilitation program for handicapped persons with no potentialities for return to employment) which would be placed in the vocational rehabilitation unit of the states. This bill (HR–3465) is being sponsored by the National Rehabilitation Association. In a widely distributed "background statement," this association declares that only vocational rehabilitation counselors have the philosophy and the experience to undertake such a program. While holding that rehabilitation for independent living is not primarily medical, the statement emphasizes that the vocational counselors have had lots of experience in running medical programs, and are perfectly capable of doing so.

Thus we see here the pattern which is characteristic of phenomena in other areas of medical care. Whenever physicians fail to exert the necessary leadership in medical problems, there will be lay groups ready to step in and do it for them. It is still our philosophy that physicians should have the key role of responsibility for problems which are primarily medical.

Thus we must face the question of "who leads in rehabilitation." Medicine is not the only discipline concerned with the rehabilitation of disabled persons, whether the objective be employment or a maximum degree of independent living. However, the physician is a very important member of that team, and if he is not the captain, he would at least appear to be the quarterback. It is up to him to determine the medical potentialities of a patient and what the patient's mental and physical status will accept.

If the physician fails to carry out this role, there is the immediate danger of unfairness to the patient who may thus not achieve his full potentialities. There is also the long-range danger of handing over medical problems to nonmedical groups on a silver platter—I. J. B.

"Hers has been a tremendous contribution to the advancement of health and life of mothers and children in our state and over the country during the devoted years of dedication to their fuller living. If we were to recount even only the most significant of her many activities, it would take many pages."

—CARL N. NEUPERT, M.D., State Health Officer

DR. AMY LOUISE HUNTER

AFTER more than twenty-five years of devoted, inspirational service to the State Board of Health as Director of the Bureau of Maternal and Child Health, Dr. Amy Louise Hunter retired from that position on January 31, 1961. Many colleagues and organizations who had worked closely with Doctor Hunter honored her at a number of testimonial affairs. Some of their comments are printed below.

* * *

"For the colossal and valiant service that you have performed in the interests of the people and the physicians of the State of Wisconsin, I wish personally to recognize your contributions and to congratulate you upon this memorable occasion, and wish you continued health and years of happiness in your well-earned retirement."

E. D. SORENSON, M.D.
President
State Medical Society of Wisconsin

"During the more than twenty-five years you have served the Wisconsin State Board of Health, you have contributed greatly to the improvement of the health of mothers and children in the State of Wisconsin."

E. R. KRUMBIEGEL, M.D.
Commissioner of Health
Milwaukee Health Department

"You have many rich memories and many gratifications over the work you have done to help the children of our state."

MRS. WOODS O. DREYFUS
Milwaukee County Mental Health Association

"Your active interest in providing a health climate in which our children might grow and your continued efforts to make this possible will be remembered by many grateful parents, teachers, and citizens of Wisconsin."

MRS. WILLIS M. VAN HORN
President
Wisconsin Congress of Parents and Teachers

"The breadth of your programs has always interested me, as have the studies for which you have been responsible. My best wishes to you in your retirement."

LEONA BAUMGARTNER, M.D.
Commissioner of Health
City of New York

"Dedicated service in the public welfare always deserves recognition from the public which has been the recipient of that service."

JAMES L. FITZPATRICK
Executive Director
Wisconsin Federation of Teachers

"Words cannot express my appreciation for the great help you have given the Division of Maternal and Child Welfare of the State Medical Society."

GEO. S. KILKENNY, M.D.

"As your representative in the Congress of the United States, I want to congratulate you for your many years of service to the cause of better health for the people of Wisconsin."

ROBERT W. KASTENMEIER
Member of Congress

25 Years in Maternal and Child Health

Dr. Amy Louise Hunter came to the State Board of Health as Chief of Maternal and Child Health on April 22, 1935. Her activities and accomplishments have been tremendous during that period.

She stimulated studies and activities on the part of the medical society having to do with prematures and neonatal deaths. Her activities as an analyzer and initiator were instrumental in getting under way many significant developments such as:

- Provision of wooden incubators (84) for use with premature infants in home deliveries and in smaller hospitals before modern incubators were available.

- Training of hospital teams in caring for premature infants.

- Recognizing the importance of early recognition of emotional health problems of children as an integral part of their growth and development, including the essential relationships and understanding on the part of their parents. Among other means of getting results there was initiated and carried on under her direction participation on the part of communities in the establishment and maintenance of child guidance centers in 14 counties over the state, beginning in 1940.

- She was largely instrumental in initiating the essential nutrition program of the State Board of Health.

- Her knowledge in promoting school health activities and getting under way the Interdepartmental Committee on School Health and her work in connection with the statewide School Health Council deserve special recognition.

- Her constructive activities in various national organizations such as the American Public Health Association, the Association of State Maternal and Child Health Directors, the 1950 and 1960 White House Conferences on Children and Youth, are among other significant accomplishments.

"Those of us who have been associated with you over nearly twenty-five years of your consecrated service in the State Board of Health are confronted with a difficult adjustment as we try to carry on without your direct, dynamic approach to the recognition of needs and ways of meeting them in the advancement of the healthful living of the mothers and children."

CARL N. NEUPERT, M.D.
State Health Officer
Wisconsin State Board of Health

"Members of our Chapter have asked me to express to you our congratulations and thanks for your great record of service to the people of Wisconsin."

RAYMOND S. MCCLELLAND
President
National Association of Social Workers
Southeastern Chapter, Wisconsin

"We, therefore, want you to know our deep appreciation for your leadership, knowledge, and contributions to the children not only of your own state, but to all the children of America."

A. O. DEWEESE, M.D.
Executive Secretary
American School Health Association

"I would like to re-emphasize both personally and as president of the Wisconsin State Board of Health my personal recognition . . . . and to add my personal commendation for your long and illustrious career . . . ."

W. T. CLARK, M.D.
President
Wisconsin State Board of Health

"With your long and illustrious tour of duty as Director of the Bureau of Maternal and Child Health drawing to a close, the family doctors of Wisconsin salute you and wish you well."

ROBERT E. CALLAN, M.D.
President
Wisconsin Academy of General Practitioners

"Twenty-five years of persistent efforts and helpful counsel to the medical profession to help improve the health of mothers and children in Wisconsin is a record which deserves sincere gratitude."

MRS. S. H. AMBROSE
President
Woman's Auxiliary to State Medical Society of Wisconsin

"Thanks to your ardor and inexhaustible enthusiasm we have here in Wisconsin a pattern that is the envy of the entire nation."

ROBERT F. PURTELL, M.D.
Milwaukee

"The National Society for the Prevention of Blindness is most grateful to you for your contributions over many years to prevention of blindness and sight conservation programs."

JOHN W. FERRELL, M.D.
Executive Director
National Society for Prevention of Blindness

"Your colleagues from other states in the nation have appreciated the vision which you have shown in the conduct of your own program and your contribution to national committee work."

MARTHA L. CLIFFORD, M.D.
Director, Community Health Division
Connecticut State Dept. of Health

"There has been great progress in the field of maternal and child health during the period of your service and your contributions to this progress have been significant."

GAYLORD A. NELSON
Governor
State of Wisconsin

"But when one person, through high intelligence and endless endeavor has saved countless lives, a fitting reward is beyond the ability of poor mortals to bestow. Your memorial is the legion of children and young adults living in Wisconsin today who simply would not have survived had it not been for your work."

WILLIAM PROXMIRE
United States Senate

"On behalf of the medical profession of this community I wish to tell you how much we have all appreciated your outstanding programs over the years."

JAMES M. SULLIVAN, M.D.
President
The Medical Society of Milwaukee County

"Of particular interest to organized dentistry was the fact that you were largely instrumental in initiating the essential nutrition program of the State Board of Health."

DAVID A. BARRETT, D.D.S.
President
Greater Milwaukee Dental Association

"Thanks to your leadership in Wisconsin, wonderful progress has been made in the field of maternal and child health."

KATHRYN GILL
Chief, Home Economics Education
Wisconsin State Board of Vocational and Adult Education

"Over the years we have watched with interest your work among the Catholic schools and institutions in Milwaukee."

MSGR. EDMUND J. GOEBEL
Superintendent of Schools
Archdiocese of Milwaukee

"Your health program undoubtedly has contributed a great deal to the alleviation of the deafness incidence among children."

ROBERT W. HORGEN
Director
Wisconsin Association for the Deaf

"It gives me great pleasure to write and thank you for the great work that you have done for women and children."

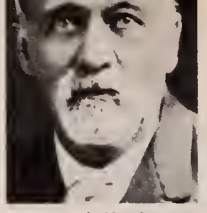
MRS. GEORGE W. SHOVER
Past President
Wisconsin Federation of Women's Clubs

"Throughout the years you have not only been instrumental in changing the picture for mothers and children in Wisconsin but also have contributed much on a national level."

HILLA SHERRIFF, M.D.
President
Association of State Maternal & Child Health Directors

"I want to take this occasion to congratulate you upon the magnificent progress which the state of Wisconsin has made under your direction in safeguarding the health of mothers and children."

HAROLD S. DIEHL, M.D.
Senior Vice President
American Cancer Society


Dr. Karl Hankwitz

Dr. Paul Hankwitz

Dr. Arthur Hankwitz

Three Generations of Physicians in Hankwitz Family

SECTION ON MEDICAL HISTORY

FROM HORSE and buggy to automobile to airplane summarizes the 65 years of medical service rendered to residents of Bay View and the south side of Milwaukee by the Hankwitz family.

Three generations, Dr. Karl Edward Hankwitz, Dr. Paul Gustav Hankwitz, and Dr. Arthur W. Hankwitz, have provided medical service to that area since 1896.

The grandfather, Dr. Karl Hankwitz, served as a military surgeon during the Franco–Prussian War of 1871. Leaving the economically distressed Germany, the family emigrated to the United States. Working his way to the midwest as a country doctor, Dr. Karl first settled in Waverly, Iowa, and practiced in Watertown and Waterloo, Wisconsin, before eventually spending his last few years of practice in Milwaukee.

First of the family to establish his practice in the Bay View area was Dr. Paul Hankwitz. Newly graduated and only 24 years old, he opened his first office, at 1262 Kinnickinnic Avenue in 1896. His father joined him in 1901 and was active in the partnership until his retirement three years later.

Dr. Paul practiced in the days when less than one per cent of the babies were born in hospitals and a large number failed to survive the first year because of "summer complaint," feeding problems, and acute infections. Diphtheria, typhoid fever and pneumonia were rampant, and hundreds of cases were seen every year by the average family doctor. Herbs, roots, leaves and plant extracts (with few synthetic compound chemicals available) were about the only medicines and these were used primarily for symptomatic relief. The doctor was his own pharmacist, laboratory technician, secretary and accountant. The patient's husband or grandmother was often his anesthetist, nurse and assistant at home confinements and in injury cases. His social life was mainly confined to visiting with his patients morning, noon and night, because of the shortage of medical help and long hours required of the family physician.

The monthly medical meetings and annual State Medical conventions usually constituted the sum total of postgraduate courses for his generation of physicians. Medical journals and abstracts were the physician's means of staying abreast of the times.

Doctor Paul Hankwitz retired in 1941 after 45 years of uninterrupted medical service, leaving his son, Dr. Arthur Hankwitz, to carry on. A graduate of Washington University Medical School, St. Louis, Missouri, in 1931, Dr. Arthur had interned at St. Louis City Hospital and carried on postgraduate work in Berlin, Germany, and Vienna, Austria, before joining his father in practice.

While his grandfather had relied on the horse and buggy during his days of practice, and his father owned the second auto in Bay View, the present generation Hankwitz found his airplane the convenient mode of transportation to make lake calls during the summers of 1946–1955.

In addition to his medical practice, he has served his community in numerous civic and fraternal activities. He is past president of nine such area organizations as well as past commander of two flying organizations and a former commander of a U.S. Coast Guard Auxiliary unit. In 1960 Doctor Arthur Hankwitz received the Civic Award presented by the Interorganizational Council of Bay View, Inc. for outstanding contributions to civic progress in the community.

Although four sons and one daughter have already expressed interest in such careers as engineering, teaching, law and music, the youngest, Paul, 12, tends toward medicine—and may very well become the fourth Hankwitz to carry on this rich family heritage in medicine.

THE MEDICAL FORUM

Doctor Fox Is Re-elected Council Chairman

The Council of the State Medical Society met February 25 and 26 at the State Medical Society building in Madison to elect officers, set the 1961 budget, and hear reports from various committees.

Dr. James C. Fox, La Crosse, was re-elected chairman of the Council for his third annual term. Also re-elected were Dr. F. L. Weston, Madison, treasurer; Dr. H. Kent Tenney and Dr. N. A. Hill, both of Madison, assistant treasurers; and C. H. Crownhart, Madison, secretary.

Dr. D. N. Goldstein, Kenosha, was re-elected editorial director of the *Wisconsin Medical Journal* and Dr. V. S. Falk, Edgerton, was named assistant medical editor, a position newly created.

In the budget considerations, the Council approved anticipated expenditures of $360,106 for the State Medical Society in the current year.

In other actions, the Council:

1. Changed the title of the Committee on Public Policy to the Commission on Public Policy.
2. Changed the title of the Committee on Federal Legislation to the Committee on Health Economics of American Life. Created as an emergency committee in 1959, it now becomes a permanent committee and appointments will be made to it in the same fashion as to other committees of the Council.

The Council also heard reports from the Commission on State Departments and the Commission on Hospital Relations and Medical Education. Highlights of these reports and actions taken are reported in other stories in this issue of the *Forum*.

PRESIDENT-ELECT OF THE STATE MEDICAL SOCIETY Dr. L. H. Lokvam, Kenosha, right, leads an informal discussion at the February meeting of the Council with, left to right, Dr. E. J. Nordby, Madison, Speaker of the House of Delegates; Dr. W. D. James, Oconomowoc, First District Councilor; and Dr. J. H. Houghton, Wisconsin Dells, Third District Councilor.

Councilor District Caucuses Scheduled Mar. 27–Apr. 15

District caucuses, in preparation for the annual meeting of the State Medical Society May 2–4, will be held in the Councilor Districts between March 27 and April 15.

County medical society presidents, secretaries, delegates and alternates meet with their councilor at the caucus to discuss the affairs of the State Medical Society and especially the reports and resolutions being presented before the House of Delegates at the annual meeting.

Following is a list of the caucuses:

Date	*District*	*Location*	*Time*
Mar. 27	2	Hob Nob, Racine	6:30 p.m.
Mar. 29	4	Graney House, Lancaster	6:30 p.m.
Mar. 30	6	Elks Club, Green Bay	6:30 p.m.
Apr. 4	7	New Villa, La Crosse	6:30 p.m.
Apr. 4	9	Hot Fish Shop, Stevens Point	6:30 p.m.
Apr. 5	10	Eau Claire Hotel, Eau Claire	6:30 p.m.
Apr. 5	13	Fenlon Hotel, Rhinelander	6:30 p.m.
Apr. 6	8	Riverside Country Club, Menominee, Michigan	4:30 p.m.
Apr. 6	11	Elks Club, Superior	6:00 p.m.
Apr. 7	1	Towne Hotel, Oconomowoc	6:30 p.m.
Apr. 8	5	Imperial Motel, Sheboygan	2:00 p.m.
Apr. 10	12	Headquarters, Medical Society of Milwaukee County	8:30 p.m.
Apr. 10	Section Delegates	State Medical Society, Madison	6:30 p.m.
Apr. 15	3	State Medical Society, Madison	4:30 p.m.

COUNCIL HEARS DETAILED REPORT ON . . .

Urgent Need For Medical School Applicants

THE STUDENT'S FINANCIAL PLIGHT

1. Over 99 per cent of all medical students work part or full time while in medical school. Deans recommend no more than 10 hours per week of outside work—yet 10 per cent of medical students work 40 hours per week or more and the average student works 15 hours weekly.

2. If funds were available, the average medical student reports he would borrow at least $4,000 in additional funds during four years of education.

3. The median amount of loans received by medical students during four years of schooling is $2,555.

4. Average cost to the student for four years of medical education is $11,642—about $9,800 for single students and up to $16,000 for married students.

5. The average student gets 82 per cent of his resources from family loans or gifts plus his own or his wife's earnings from employment. About 18 per cent of his funds comes from outside scholarships and loans.

6. Only 14 per cent of medical student graduates come from families earning $5,000 or less annually. Forty-three per cent come from families with over $10,000 annual income. Thus a major method of increasing the number of physicians is to broaden the socio-economic base from which they are drawn.

7. Increasing financial aid is available to Wisconsin medical students through the Charitable, Educational and Scientific Foundation of the State Medical Society. While many applications are still pending for lack of funds, the Foundation already has nearly $80,000 out on loan at the present time. Through funds such as those in the Foundation, medical students can normally be assured of sufficient financial aid to complete studies once begun.

"During the past few months, the Commission on Hospital Relations and Medical Education has been impressed with the obvious necessity for urgent and vigorous action to deal with the growing shortage of qualified applicants for medical school."

Thus began the report of this Commission, presented to the Council on February 25 by its chairman, Dr. R. S. Gearhart, Madison.

"There is general agreement in the Commission that dwindling interest in the field of medicine has almost reached the crisis stage," the report stated.

With this in mind, the Commission, through its committee on medical education, has already initiated the following activities:

1. A pilot program of medical student recruitment has been started in three areas of the state. Its purpose is to provide intensive contact with high school students through interviews, addresses to school convocations, personal physician relationships, medical student contact, news media and guidance counseling. If this proves successful, it will be expanded to all county medical societies.

2. Teachers and guidance counselors are being made aware of the critical shortage of qualified applicants to medical schools through communications from the office of the State Department of Public Instruction and the Wisconsin Educational Association.

3. The March of Medicine radio program of the State Medical Society is being utilized to bring an important message on this topic to 53 Wisconsin radio stations with an estimated listening audience of 500,000. Tape recordings of this program are also being made available to high schools for use in guidance classes, and other classes in an effort to dispel some of the "myths about medical education."

4. In cooperation with the State Medical Society's Commission on Public Relations and Communications, an extensive health careers brochure is being prepared for widespread distribution throughout the state to young people interested in medicine and related careers. Primary emphasis will be placed on the needs in the medical field. A considerable variety of audio visual aids for recruitment is also available to any interested person or group.

The Commission stressed that support from all county medical societies and individual physicians is needed in seeking to interest a substantial number of young men and women in medicine as a career.

PIN-POINTING THE PROBLEM

1. Wisconsin has about 104 physicians per 100,000 of population; the United States as a whole has about 135.

2. With respect to the ratio of applicants for medical school to population, Wisconsin ranks 44th in the nation.

3. The annual rate of newly licensed physicians is low for Wisconsin, 2.8 per 100,000 population as compared with 4.6 for the United States.

4. Wisconsin ranks 25th among the 50 states in the number of active nonfederal physicians in relation to population. The rate is 98 per 100,000 as compared with the national average of 118 per 100,000.

5. More than half of Wisconsin medical school graduates move to practices outside Wisconsin. Although in previous years this was offset by the fact that about 50 per cent of physicians practicing in Wisconsin graduated from schools outside the state, since 1954 this number has decreased to about 33 per cent.

6. In order to raise the ratio of physicians to population up to the national average, replace physicians who retire or die, and provide for an increasing population, an average of about 240 new physicians will be needed each year for the next 15 or 20 years. The current number being added each year is only about 135.

Name Principal Speakers For Conference On Children—Youth

"Adventures in a New and Strange Land" is the theme of the Seventh Governor's Conference on Children and Youth, to be held April 7–8 in Madison.

Among the speakers who will appear during the conference are Governor Gaylord **Nelson**; Mrs. H. L. **Garner**, Madison, general chairman; Carl **Winters**, Oak Park, Ill., former chairman of the Michigan Crime Commission; Harry **Hamilton, Jr.**, Madison, University of Wisconsin graduate student who is active in youth activities; Dr. H. Kent **Tenney**, Madison, chairman of the Wisconsin Committee on Children and Youth; and Donald **Brieland**, Chicago, executive director of the Elizabeth McCormick Memorial Fund and a member of the National Committee on Children and Youth.

Registration begins at 8 a.m. April 7 in the Wisconsin Center Building on the campus, and the opening session is at the Memorial Union Theater starting at 10 a.m. Forums and workshops will be held during the day and a theatrical production will be held Friday evening. The closing session will be held starting at 9:15 a.m. on Saturday.

Dr. L. M. **Simonson**, Sheboygan, is the State Medical Society's delegate to the conference.

BELOIT'S OUTSTANDING CITIZEN, Dr. William J. Allen, right, admires a plaque presented to him by James Haight, Beloit Junior Chamber of Commerce president. Doctor Allen, a 50-year member of the Rock County and State Medical societies, received the award in February.

The Law and You

The State Bar of Wisconsin Public Information Service

If you are injured in a hospital due to the negligence of one of its agents or employees, can you bring an action and recover damages? Can a hospital escape liability for its negligent acts simply on the ground that it is a charitable institution?

The parents of Joyce, a young lady of 4, were informed by her doctor that she should have her tonsils removed. She was taken to a local hospital to have the operation.

Her mother had told the doctors that Joyce rolled and tossed in her sleep a great deal, and asked that guard rails be provided to protect her from falling out of bed. The guard rails were not used. During the night little Joyce rolled out of bed in her sleep, fell to the floor, and broke her leg.

Joyce, through her mother as guardian, brought a legal action against the hospital to recover damages for the injury she incurred due to the negligence of its staff in not adequately protecting her.

The hospital stated that they were a charitable institution and as such were exempt from liability.

Could Joyce recover?

Yes, she can. The Wisconsin Supreme Court, in a recent decision, said that it will not recognize the defense of charitable immunity in cases where a paying patient is seeking recovery for the negligent acts of the hospital, its agents, servants, or employees. Even assuming that the hospital is a charitable institution, it cannot escape liability for negligence simply upon this point alone.

In so deciding, the Court reversed all of its prior decisions to the contrary.

Reservations Open For Medical Golf Tourney

The Wisconsin State Medical Golf Association Tournament will be held Monday, May 1, at the Ozaukee Country Club.

The price of $14 includes green fees, prizes, dinner and entertainment. Those attending only the dinner will pay $7 and those participating only in the golfing will pay $7.

Reservations may be made with Mr. A. H. Luthmers, Executive Secretary, Wisconsin State Medical Golf Association, 756 North Milwaukee Street, Milwaukee 2, Wisconsin.

HAVE YOU LOOKED AT YOUR INCOME PROTECTION LATELY?

Is your disability income insurance up-to-date?

To find out, apply these tests:

- *Is your sickness coverage limited to only five or ten years? Or does it cover you to age 65 as Time plans do?*
- *Does it demand total disability from the start, or does it compensate you (as Time plans do) if unable to perform the duties of your occupation for 2 to 5 years?*
- *Are you paying much more premium than you would under a comparable Time plan?*

If the answer to any of the above questions is "yes", we suggest you contact your Time representative without delay.

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DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION, Dr. E. L. Bernhart, left, and Dr. R. E. Galasinski, right, both of Milwaukee, are shown above during the meeting of the Council in Madison February 24.

Initiate New WPS Bulletin

WPS Outlook, a new bulletin designed to communicate facts and comments about Wisconsin Physicians Service and the socio-economic outlook on medicine and health, is a new publication of the Commission on Medical Care Plans of the State Medical Society.

Outlook was authorized by the Commission on Medical Care Plans for distribution to all members of the society. It will be issued as often as twelve times each year, depending upon the urgency of the message.

The bulletin will be a special effort to provide physicians and their office assistants with facts to assist them in better understanding of WPS, more rapid and satisfactory claims processing, and greater knowledge of current economic situations.

Sears–Roebuck Foundation Aids Colfax And Arcadia

Colfax, Wisconsin, submitted its application to the Sears–Roebuck Foundation in January for a survey under the foundation's Community Medical Assistance Program.

Arcadia is currently listed as a cooperating community with the foundation.

Policy Statement Issued On "No Fee Schedule" Contracts

The availability of the state and county medical society facilities to service the "no fee schedule" contracts of the State Medical Society was the object of a recent action of the Council.

The full policy statement of the Council is as follows:

"The Commission on Medical Care Plans of the State Medical Society has long been sensitive to the possibility of other insuring organizations seeking to sell a surgical-medical contract in which the benefits are measured by the customary and reasonable charges of a medical community.

"This is the Special Service (no fee schedule) concept of the State Medical Society which has been available since 1955 and which was found to be a workable program under the auspices of the State Medical Society, using to the maximum the assistance of a local advisory committee.

"Administration of the Special Service concept is unique and some difficulties are not fully appreciated by the medical profession itself, and certainly not by the insurance industry. A decision with reference to the benefit to be paid under one set of circumstances is not necessarily a precedent for the benefit to be paid for an identical procedure but involving other circumstances, such as another medical community, a more complicated case, a longer period of hospitalization.

"The State Medical Society considers that the problem of amount to be paid is essentially one existing between it and the physician, and that the beneficiary must not be embarrassed or concerned by delays that may ensue as a result of careful evaluation of some procedures, nor should the beneficiary feel that he may be the object of suit for additional fees, and to that end the State Medical Society agrees that if a patient should be sued by a physician, the Society will intervene as a party defendant to the action and will hold the defendant harmless of any liability.

"Neither is the Special Service concept one which can be confined to a specific geographic locality. In these days of easy modes of travel, employees of a group may very possibly receive treatment in various different areas of the country. The Commission on Medical Care Plans does not see any practical way for either the State Society or a county society to provide the administrative technique and involved details to other insurance organizations. This requires a concentration of effort and a continuity of purpose.

"However, should any insurance organization, duly licensed in Wisconsin, care to offer the Special Service contract of the State Medical Society, the Commission on Medical Care Plans will cooperate in such manner that the insurance company and its appropriate employees be designated as special agents for such special purposes. In this capacity they would be in a position to offer the Special Service contract underwritten by WPS in conjunction with other elements of a health insurance 'package.' Any such arrangement would retain the autonomy of the medical profession, but permits insurance companies to offer the same device which the medical profession is providing in the public health interest."

THOUSAND PHYSICIANS JOIN NEW YORK UNION

Physicians and dentists in the New York City Health Department have set up a union, believed to be the first such organization for such professions in the United States, according to the *Racine Journal–Times*.

The group, known as the Doctors' Association of New York, has 1,000 members. Announced objectives are salary increases, tenure and pension rights.

State Of Wisconsin Employees Basic WPS Coverage Renewed

The State of Wisconsin Employees Group has renewed its basic surgical-medical coverage with Wisconsin Physicians Service, effective April 1.

Approximately 17,000 employees are enrolled in the group.

They carry coverage which is similar to the Special Service plan of WPS, and involves the no fee schedule concept whereby the policy pays the "reasonable charges" of the physician, rather than a set monetary figure for any one procedure.

WPS originally enrolled the group on April 1, 1960. The present contract will run until March 31, 1962.

State Renews Major Illness

Renewal of Wisconsin Physicians Service major-medical coverage for the State of Wisconsin Employees Group, along with a special open enrollment period, has been announced.

The 2,300 employees who carried their major-medical coverage with WPS during the past year will be renewed effective April 1.

Meanwhile, in an open enrollment which started on February 1 and continues to March 28, 4,200 additional employees have selected WPS for their major-medical coverage.

This brings to about 16,200 the total number of state employees and their dependents who have the WPS major illness coverage.

Those eligible in this open enrollment are employees who carry the basic surgical-medical and hospital coverage, but do not have major-medical coverage at this time.

ON THE HORIZON

Apr. 7–8—Governor's Conference on Children and Youth, Madison.

Apr. 30—Museum of Medical Progress opening, Prairie du Chien.

May 1—Wisconsin State Medical Golf Association Tournament, Ozaukee Country Club.

May 2–4—State Medical Society of Wisconsin Annual Meeting, Milwaukee.

May 19—University of Wisconsin Medical School Alumni Day, Madison.

FOLDER AVAILABLE AS MAILING PIECE

A pamphlet entitled "Socialized Medicine and You" is now available to physicians for use as an envelope stuffer.

They may be ordered from the State Medical Society of Wisconsin, or directly from the Department of Special Services, Communications Division, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

The pamphlet is derived from a double-page advertisement in the February 20 issue of the *AMA News*.

Grants For Postgraduate Training In Public Health

The Public Health Service is now accepting applications for graduate training in public health for the 1961–1962 academic year.

The awards provide stipends for living expenses of the trainees in addition to tuition and fees.

Information and application forms may be obtained from the Division of Community Health Practice, Public Health Service, Washington 25, D.C.

COUNTY SOCIETIES VIEW DOCTOR ANNIS

Two county medical societies, Brown and Portage, recessed their meetings in February to watch the television debate between Dr. Edward Annis and Walter Reuther over the CBS television network.

Cancer–Heart Institute Set

A Cancer-Heart Institute will be held April 5 at Luther Hospital in Eau Claire from 2 to 5:30 p.m. It will be followed by the 10th District Caucus that evening.

The program is as follows:

2:00 p.m.—"Skin Cancer and Lesions Commonly Seen in Your Practice", Dr. Sture A. M. **Johnson**, professor of dermatology, University of Wisconsin Medical School.

2:30 p.m.—"Obesity and Exercise as Factors in Heart Disease", Dr. E. S. **Gordon**, professor of medicine, University of Wisconsin Medical School.

3:00 p.m.—Coffee break.

3:30 p.m.—"Role of X-Ray Therapy in the Treatment of Breast Cancer", Dr. Halvor **Vermund**, professor of radiology, University of Wisconsin Medical School.

4:00 p.m.—"Current Treatment of Leukemia", Dr. Robert **Schilling**, associate professor of medicine, University of Wisconsin Medical School.

4:00–5:30—Wet Clinic and Case Discussions. Cases in all areas covered will be presented by local physicians and used as a basis for discussion.

Dr. John H. **Wishart**, Eau Claire, president, 10th Councilor District, will be moderator.

All members of the 10th Councilor District attending the institute are invited to attend the dinner and caucus meeting starting at 6:30 p.m.

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Business Consultants to the Medical Profession.

Inquiries Invited

INSTITUTION PATIENTS BENEFIT IN . . .

Kenosha Medical Society's Prepayment Plan

A great deal of interest has been shown both in Wisconsin and outside the state in the Kenosha County Medical Society's prepayment plan for furnishing medical services to county institutions.

More than half a year has passed since the unique plan was instituted, and although the period of operation has been too short to fully assess the Kenosha institutions idea, the society feels "with continued sincere application by all interested parties there can be no doubt about successful achievement of the goal—the finest patient care at the lowest cost, with retention of the best features of American medicine."

Two Institutions Covered

The agreement between the county and the medical society covers two institutions, Brookside and Willowbrook.

Brookside is a home primarily for the aged with an average census of 209 patients, the great majority welfare recipients over the age of 75. The services rendered go far beyond those available in the average nursing home for the aged and in many cases fall just short of full hospital care. A great number of patients have chronic diseases that require frequent medical attention as well as complete nursing service.

The full time staff includes six registered nurses, eight licensed practical nurses, 46 nurses aides and three male attendants. Additional persons work in these categories part time.

Willowbrook is a tuberculosis sanatorium with a capacity of 40 patients. It has operated at about 75 per cent capacity for the past five years, but occupancy declined to 30 per cent at the end of 1960. In addition an outpatient service is offered, with more than 2,500 visits during the past fiscal year.

The nursing staff includes three registered nurses and four nurses aides, and there is a full time laboratory and x-ray technician.

History Of Problems

During a considerable portion of the history of the two institutions, medical service was furnished on a part time basis. About four years ago services of a full time physician were secured, with this medical director dividing his time about equally between Willowbrook and Brookside, and also conducting the outpatient tuberculosis clinic. His chief interest and training had been in the field of tuberculosis and he freely utilized the services of various physicians in private practice to handle medical problems arising at Brookside.

Early in 1959 news of contention between the medical director and the trustees began to appear in the local press. Charges and countercharges rapidly received increasing publicity, leading finally to what appeared to be a division of patients, staff, public officials and others into rival camps.

In December, 1959, Willowbrook Sanatorium lost its rating as an accredited institution by the Joint Commission on Accreditation of Hospitals, presumably due to the fact that it had no medical staff active in the work of the sanatorium. The patients at Brookside, the majority of them welfare recipients, were not allowed the services of their previous physicians although many had been under the care of local physicians for several decades.

The public dispute culminated in the resignation of the medical director, effective June 21, 1960.

Medical Society Contacted

Following his resignation, the Kenosha County Medical Society was contacted to provide assistance in resolving the difficulties in the institutions and to help obtain medical services after June 1.

A special committee of the county society met with the trustees and administrator to assure medical care for the patients. The committee also agreed to make a thorough study of the needs of the

A SPECIAL EASTER SEAL DISPLAY at the State Medical Society building attracts the attention of, left to right, Dr. W. P. Curran, Antigo; Dr. L. O. Simenstad, Osceola; and Dr. E. J. Nordby, Madison. The physicians were attending the Council meeting in February. The display features Easter Seals from past years, and mechanical banks from the collection of Dr. T. W. Tormey, Jr., Madison.

A UNIQUE COLLECTION OF BANKS, the property of Dr. T. W. Tormey, Jr., Madison, is now on display at the State Medical Society building in Madison. Doctor Tormey is shown above with one of the 11 mechanical banks and 14 nonmechanical banks in the collection.

ENGAGED IN A DISCUSSION at the February meeting of the Council are, left to right, Dr. H. J. Kief, Fond du Lac; Dr. E. M. Dessloch, Prairie du Chien; and Dr. R. W. Mason, Marshfield. Doctor Kief is Councilor for the Sixth District, Doctor Dessloch for the Fourth District, and Doctor Mason for the Ninth District.

institutions and examine factors that could prevent a recurrence of a similar situation in the future.

Propose Prepayment Plan

A series of meetings followed with staff personnel, public officials, representatives of the State Medical Society, and the retiring medical director. The result was the proposal of a plan wherein the local medical society would provide complete medical care for all Brookside patients receiving public welfare assistance, and all Willowbrook patients, on a prepayment basis.

The society would appoint a medical director and assistants to coordinate and supervise the provision of medical services, would permit each patient to select his own personal physician, arrange for tuberculosis consultants for inpatient and outpatient services at Willowbrook, and process and pay the claims of all physicians for the medical services rendered.

Numerous Advantages

The advantages would be the improvement of the quality of patient medical care by assuring the continuity of such care, free choice of physician, development of a medical staff, reduction of political influences associated with government medical care programs, and the constant supervision of all medical services provided.

In short, all of the best features of the private practice of medicine would be available to the patients at the county institutions.

Agreement Reached

On June 20, 1960, the agreement was reached with the trustees, and the Kenosha County Medical Society instituted its program under its division known as Kenosha Physicians Service. The initial terms extended to June 30, 1961, with renewal at one-year intervals unless there is prior notice by either party.

One hundred per cent of the active practicing physicians of the Kenosha County Medical Society signed participating agreements covering services under the prepayment plan.

By its terms each agreed to accept a pro-rata reduction of his fee for services rendered to Brookside or Willowbrook patients in the event that the payment by the county should be insufficient to cover the total of all statements for medical services.

The agreement also provides that if the payments from the trustees to the society exceed the total charges of participating physicians, the surplus may be transferred by the society to one or more charitable, educational or scientific endeavors.

Although this method of providing medical care is by no means new, so far as is known it is the only prepayment plan wherein physicians' services are furnished long-term institutionalized patients on such a basis.

Many Ideas Incorporated

Each resident at Brookside has a personal physician, and the coverage for his medical needs is five deep—if his personal physician is unavailable his designated alternate is called, next a physician on rotating emergency call duty is maintained by the county medical society, then the assistant medical director, and finally the medical director.

A formulary of drugs has been developed utilizing generic names with the anticipation of considerable savings to the county.

At Willowbrook a tuberculosis specialist conducts an outpatient clinic once a week and makes regular visits to the inpatients, directing their treatment. In August 1960 a complete review of all the Willowbrook inpatients was conducted by two tuberculosis specialists from the University of Wisconsin and Marquette University medical schools.

The local physician who acts as medical director at Willowbrook makes regular visits and the services of family physicians are utilized for medical problems of a nontuberculous nature.

There is continuing study of improved use of the facilities and more economical and efficient provision of ancillary services.

Costs Are Reduced

The prepayment fee initially established for the physicians' services was approximately the same amount budgeted for physicians' fees about a year ago. On January 1, 1961, Kenosha Physicians Service reduced its charge to the county by 15 per cent—in spite of the fact that quality and quantity of medical services undoubtedly increased over the period.

COUNCIL CHAIRMAN Dr. James C. Fox, La Crosse, was re-elected to a third term in office at the meeting of the Council February 24–25 in Madison.

A PROBLEM OF CONSIDERABLE PROPORTION . . .

Filling Approved Internship Program Quotas

"The inability of most Wisconsin hospitals to attract sufficient numbers of medical graduates to fill approved internship program quotas is becoming a problem of considerable proportion," stated the Commission on Hospital Relations and Medical Education in its report to the Council of the State Medical Society on February 25.

To point up the problem, the Commission reported that for the internship year July 1, 1960, to June 30, 1961, 21 Wisconsin hospitals sought 229 interns. The National Intern Matching Plan matched 74 interns to these vacancies for a 32.3 per cent result.

In addition to this number of interns matched to hospitals offering intern programs, additional vacancies were filled from unmatched students, nonparticipants, and graduates of foreign medical schools. No final record of the number of intern vacancies after these additional appointments by hospitals is available.

Problem Not New

Concern over the situation is not a new item for the Commission. In December, 1960, The Medical Society of Milwaukee County petitioned the Council by resolution to instruct the Wisconsin delegates to the American Medical Association to ask for an investigation of the procedures and powers of the Council on Medical Education and Hospitals of the AMA in the establishment and approval of internship programs. This resolution also asked "why some Milwaukee hospitals were unable to attract interns and thus suffer the potential withdrawal of approval of the internship program."

Action on the resolution was withheld at that time to gain further information and suggestions regarding the problem. Since then representatives of the county medical society, the state Commission on Hospital Relations and Medical Education, and the American Medical Association have met for discussion.

"It is apparent that the problem of adequate internship and resident training programs in Wisconsin involves all hospitals offering such programs, and affects the well-being of medical care throughout the state," the Commission stated in its report to the Council.

Makes Recommendations

Stating that the ability of the state's hospitals to attract interns and residents is closely related to the number of physicians who ultimately decide to practice in Wisconsin, the Commission recommends the following:

1. Invite the Council on Medical Education and Hospitals of the American Medical Association to meet with the State Medical Society Commission on Hospital Relations and Medical Education to discuss in detail the Wisconsin postgraduate medical education problem.

2. Following the meeting with the AMA Council, call a meeting of the State Medical Society Commission with representatives from the medical staffs and administration of all hospitals in the state which have approved programs for internship and residency training.

3. Encourage medical staffs and hospitals to formulate well-rounded and attractive educational opportunities for the intern and resident so as to lift the "rating" of Wisconsin programs in comparison with similar training programs elsewhere.

4. Encourage young physicians completing various educational programs in Wisconsin hospitals to give greater consideration to the many possibilities for rewarding practice in Wisconsin.

NATIONAL INTERN MATCHING PROGRAM
Wisconsin, July 1, 1960–June 30, 1961

	Sought	Matched
Eau Claire:		
Luther Hospital	6	1
Fond du Lac:		
St. Agnes Hospital	6	0
Janesville:		
Mercy Hospital	5	0
La Crosse:		
La Crosse Lutheran Hospital	6	0
St. Francis Hospital	8	0
Madison:		
Madison General	14	6
Methodist Hospital	5	0
St. Mary's Hospital	10	1
University Hospitals	22	17
Marshfield:		
St. Joseph's Hospital	7	5
Milwaukee:		
Columbia Hospital	10	0
Evangelical Deaconess	12	0
Milwaukee County Hospital	36	34
Misericordia Hospital	6	0
Mount Sinai Hospital	14	2
St. Joseph's Hospital	12	1
St. Luke's Hospital	10	1
St. Mary's Hospital	16	1
St. Michael's Hospital	8	0
Wausau:		
St. Mary's Hospital	4	0
	229	74

Wisconsin Medicine Progressing in a Free Society

STATE MEDICAL SOCIETY OF WISCONSIN

ANNUAL MEETING

MAY 2, 3 and 4, 1961

MILWAUKEE AUDITORIUM

HOTEL SCHROEDER—MILWAUKEE

R. B. LARSEN, M.D.
General Program Chairman

M. C. F. LINDERT, M.D.
Chairman, Commission on Scientific Medicine

R. W. FARNSWORTH, M.D.
Chairman, Roundtable Luncheons

Each year brings new discoveries and varying modes of therapy of concern to every alert physician. With this in mind the Commission on Scientific Medicine has arranged a varied and interesting program for the 1961 Annual Meeting. *Wisconsin Medicine Progressing in a Free Society* is an apt theme, and we hope that you and your associates will participate in the meeting by way of your attendance. You will note that the major specialty groups, as well as the area of general practice, are represented in the program. Thinking of our responsibilities to all segments of the profession, we have attempted to provide a variety of programs for your benefit. We urge you to progress with Wisconsin Medicine by attending the Annual Meeting and attending programs of special interest to you.

Sincerely,

M. C. F. Lindert, M.D.
Chairman, Commission on Scientific Medicine

1961 ANNUAL MEETING
TIMETABLE

MONDAY, MAY 1

All Day—Golf Tournament: Ozaukee Country Club
7:00 p.m.—House of Delegates at Hotel Schroeder

TUESDAY, MAY 2

8:00 a.m.—Registration at Auditorium
Exhibits open at Auditorium
9:00 a.m.—Reference Committees, House of Delegates, at Hotel Schroeder
10:00 a.m.—Clinical Conferences: Marq. U. and U. of W. medical schools, Milwaukee Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Marq. U. and U. of W. medical schools' alumni luncheons at Auditorium
2:00 p.m.—Section Meetings on Internal Medicine, Obstetrics and Gynecology, Pathology and Psychiatry at Auditorium
6:00 p.m.—Buffet for Delegates and Officers at Hotel Schroeder
7:00 p.m.—House of Delegates at Hotel Schroeder
8:00 p.m.—Fireside conferences at Hotel Schroeder

WEDNESDAY, MAY 3

8:00 a.m.—Registration at Auditorium
9:00 a.m.—Exhibits open at Auditorium
9:00 a.m.—House of Delegates at Hotel Schroeder
9:00 a.m.—Internal Medicine Program at Auditorium
10:00 a.m.—General Practice Program at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Luncheon for officers and members of SMS Charitable, Educational and Scientific Foundation at Hotel Schroeder
12:15 p.m.—Luncheon for Wisconsin Clinic Managers Association at Milwaukee Athletic Club
2:00 p.m.—Section Meetings on General Practice, Gastroenterology, Orthopedic Surgery and Pediatrics at Auditorium
6:15 p.m.—President's reception
7:15 p.m.—Annual dinner

THURSDAY, MAY 4

8:00 a.m.—Registration at Auditorium
9:00 a.m.—Exhibits open at Auditorium
10:00 a.m.—General Scientific Program at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Past president's luncheon
1:00 p.m.—Program on Ophthalmology and Otolaryngology at Hotel Schroeder
2:00 p.m.—Section Meetings on Anesthesia, Radiology, and Surgery at Auditorium

ANNUAL MEETING PROGRAM
ARRANGEMENTS UNDER DIRECTION OF

Commission on Scientific Medicine

M. C. F. Lindert, M.D., Chairman_____Milwaukee
Roy B. Larsen, M.D._____Wausau
General Program Chairman
Richard Farnsworth, M.D._____Janesville
Roundtable Luncheons
Anthony R. Curreri, M.D._____Madison
Scientific Exhibits
P. T. Bland, M.D._____Westby
Special Assignments
John Z. Bowers, M.D._____Madison
Dean, University of Wisconsin Medical School
J. S. Hirschboeck, M.D._____Milwaukee
Dean, Marquette Universty School of Medicine
R. S. Baldwin, M.D._____Marshfield
Medical Editor, *The Wisconsin Medical Journal*

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★ **REGISTRATION:** Pick up your badge at the registration desk, inside of main entrance of Milwaukee Auditorium, Fifth and Kilbourn Streets. The time: Tuesday, 8:00 a.m.–4:30 p.m.; Wednesday and Thursday, 8:00 a.m.–4:00 p.m. Admittance by badge only.

★ **CERTIFIED GUESTS:** Medical students, medical assistants and hospital personnel will be admitted on Wednesday, May 3, after 12:00 noon, or Thursday, May 4, between 9:00 a.m. and 3:00 p.m. Interns and residents admitted without registration fee, if certified by hospital. Members of the Wisconsin State Dental Society and out-of-state physicians who are members of their county and state medical societies admitted by membership cards.

★ **VA AND M.D.'s IN MILITARY SERVICE:** *Members of the Veterans Administration must be members of the State Medical Society to be admitted.* Physicians in the armed services admitted by presenting certification of current military status.

BEFORE LEAVING FOR MEETING
GIVE YOUR SECRETARY THIS INFORMATION

TELEPHONE SERVICE: Registration Desk, Milwaukee Auditorium—**BR 1–9609.** *For Milwaukee MDs, Direct call through BR 1–4131 and it will be relayed to a special phone near the main meeting hall at the Auditorium.* For those at Luncheons: 5th Floor Foyer phone at Hotel Schroeder—BR 1–7250. Tell your secretary the room number of the luncheon, so we can locate you!

Out-of-State Guest Lecturers

HOLLIS G. BOREN, M.D.
Director of Research Laboratories, Veterans Administration Hospital, Houston, Tex.

DAVID T. CARR, M.D.
Assistant Professor of Medicine, Mayo Foundation Graduate School, University of Minnesota, Rochester, Minn.

TAGUE CHISHOLM, M.D.
Clinical Associate Professor of Surgery, University of Minnesota Medical School, Minneapolis, Minn.

GEORGE D. DAVIS, M.D.
Section of Diagnostic Roentgenology, Mayo Clinic, Rochester, Minn.

M. EDWARD DAVIS, M.D.
Joseph Boliver De Lee Professor of Obstetrics and Gynecology and Chairman, Department of Obstetrics and Gynecology, University of Chicago Medical School, Chicago, Ill.

EDWIN J. DE COSTA, M.D.
Associate Professor of Obstetrics and Gynecology, Northwestern University School of Medicine, Chicago, Ill.

BENJAMIN FELSON, M.D.
Professor and Director, Department of Radiology, University of Cincinnati, Cincinnati, Ohio.

MR. HARRY W. GINTY
Vice-president, The Medical Protective Co., Fort Wayne, Ind.

J. R. HELLER, M.D.
President, Memorial Sloan-Kettering Cancer Center, New York City.

JEROME A. HILGER, M.D.
Clinical Professor of Otolaryngology, University of Minnesota Medical School, Minneapolis, Minn.

ROBERT C. HORN, M.D.
Department of Pathology, Henry Ford Hospital, Detroit, Mich.

HAROLD ISRAEL, M.D.
Associate Professor of Internal Medicine, Graduate School, University of Pennsylvania, Philadelphia, Pa.

ALAN J. KANTER, M.D.
Chief of Hypertensive Clinic, Michael Reese Hospital, Chicago, Ill.

KENNETH K. KEOWN, M.D.
Professor of Anesthesiology, University of Missouri Medical Center, Columbia, Mo.

GEORGE B. LOGAN, M.D.
Section of Pediatrics, Mayo Clinic, Rochester, Minn.

D. B. RADNER, M.D.
Director, Chest Department, Michael Reese Hospital, Chicago, Ill.

KENNETH L. ROPER, M.D.
Professor of Ophthalmology, Northwestern University School of Medicine, Chicago, Ill.

J. L. A. ROTH, M.D.
Associate Professor of Gastroenterology, University of Pennsylvania Graduate Medical School, Philadelphia, Pa.

RICHARD C. SCHNEIDER, M.D.
Associate Professor of Neurosurgery, University of Michigan Medical School, Ann Arbor, Mich.

SOMERS H. STURGIS, M.D.
Clinical Professor of Obstetrics and Gynecology, Harvard Medical School, Boston, Mass.

FREDERICK VAN BERGEN, M.D.
Associate Professor of Anesthesiology, University of Minnesota, Minneapolis, Minn.

OWEN H. WANGENSTEEN, M.D.
Professor of Surgery, University of Minnesota Medical School, Minneapolis, Minn.

HOUSE OF DELEGATES

Meetings of the House of Delegates are regarded as among the most important functions of the Annual Meeting of the State Medical Society. Reports of the officers and committees, as well as new business, will be presented at the initial session of the House at 7:00 p.m., Monday, May 1.

On Tuesday morning at 9:00, the reference committees will meet.

It is a privilege as well as an opportunity for any member of the Society to appear before these committees and present his views on any matter properly before them. Any member, whether he wishes to appear before the committees or merely to listen in on their deliberations, is urged to participate in this extremely important phase of Society activities.

You are also invited to attend the other sessions of the House at 7:00 p.m. Tuesday and 9:00 a.m. Wednesday.

MILWAUKEE AUDITORIUM

Program—Annual Meeting

STATE MEDICAL SOCIETY OF WISCONSIN

May 2-3-4, 1961 Milwaukee Auditorium and Hotel Schroeder

Tuesday—May 2

10:00 A.M.—CLINICAL CONFERENCES

I. MARQUETTE UNIVERSITY SCHOOL OF MEDICINE

PLANKINTON HALL—Milwaukee Auditorium
Moderator: John S. Hirschboeck, M.D., Dean, Milwaukee

10:00—PAIN RELIEF IN ADVANCED CANCER
Jay J. Jacoby, M.D., Milwaukee

10:15—PRESERVATION OF CELLS AND TISSUES BY FREEZE-DRYING
Donald Greiff, ScD., Milwaukee

10:30—A REVIEW OF AVAILABLE ANTITUMOR CHEMICALS FOR CLINICAL HUMAN USE
John D. Hurley, M.D., Milwaukee

10:50—THE DIAGNOSIS AND TREATMENT OF HYPERTENSION SECONDARY TO HYPERALDOSTERONISM
Larry G. Carey, M.D., Milwaukee

11:05—DIAPHRAGMATIC REPLACEMENT; SURGICAL TECHNIQUES
Wilson Weisel, M.D., Milwaukee

11:20—THE THEORETICAL BASIS AND CLINICAL APPLICATION OF THE PROTHROMBIN TIME AND PROTHROMBIN CONSUMPTION TIME
Armand J. Quick, M.D., Milwaukee

II. UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

ENGELMANN HALL—Milwaukee Auditorium
Moderator: John Z. Bowers, M.D., Dean, Madison

10:00—THE ANESTHESIOLOGIST OUTSIDE OF THE OPERATING ROOM
James H. Barbour, M.D., Madison

10:20—RHEUMATOID ARTHRITIS; PROBLEMS IN THERAPY
John Z. Bowers, M.D., Dean, Madison
John H. Flinn, M.D., Madison

10:40—RECENT PROGRESS IN MEDICAL GENETICS
Charles W. Cotterman, Ph.D., Madison

11:00—REHABILITATION OF PATIENTS WITH INJURIES OF THE SPINAL CORD
Arthur A. Siebens, M. D., Madison

11:20—CELL CULTURE; A STUDY OF NORMAL AND MALIGNANT GROWTH
Gerald Mueller, M.D., Madison

11:40—RECENT ADVANCES IN CARDIAC SURGERY
William P. Young, M.D., Madison

12:15 P.M.—NOON LUNCHEONS

MILWAUKEE AUDITORIUM

1. **MARQUETTE UNIVERSITY SCHOOL OF MEDICINE ALUMNI ASSOCIATION**

   MARKET HALL. Reservations should be made through Mr. Ray Pfau, 620 N. 14th St., Milwaukee 3. $2.50

2. **UNIVERSITY OF WISCONSIN MEDICAL SCHOOL ALUMNI ASSOCIATION**

   JUNEAU HALL. Reservations should be made through Mr. Ralph Hawley, 418 N. Randall St., Madison 6. $3.50 (Including cocktails)

   Speaker: **V. E. Suomi, Ph.D.**, Professor of Meteorology.

   Subject: **Medical Significance of Space Satellites.**

HOTEL SCHROEDER

(See reservation form on page 238)

1. **PROBLEMS IN THE HISTOLOGIC DIAGNOSIS OF THYROID CANCER**

   Robert C. Horn, Jr., M.D., Detroit, Mich.

   Moderator: Joseph Lubitz, M.D., Milwaukee

   EAST ROOM—5th FLOOR

2. **TREATMENT OF PRIMARY DYSMENORRHEA**

   Somers H. Sturgis, M.D., Boston, Mass.

   Moderator: Benjamin E. Urdan, M.D., Milwaukee

   ENGLISH ROOM—5th FLOOR

3. **CAN A PHYSICIAN'S CONDUCT BE MEDICALLY SCIENTIFIC, AND YET LEGALLY IN VIOLATION OF THE LAW?**

   Mr. Harry W. Ginty, Vice-president, The Medical Protective Co., Fort Wayne, Ind.

   Moderator: Elston L. Belknap, M.D., Milwaukee

   PERE MARQUETTE ROOM—5th FLOOR

2:00 P.M.—SPECIAL PROGRAMS

I. INTERNAL MEDICINE*

PLANKINTON HALL—Milwaukee Auditorium

Moderator: Helen A. Dickie, M.D., Madison

2:00—SARCOIDOSIS
Harold Israel, M.D., Philadelphia, Pa.

2:30—MANAGEMENT OF ATELECTASIS IN BRONCHIAL ASTHMA
D. B. Radner, M.D., Chicago, Ill.

3:00—Recess to View Exhibits

3:45—PLEURISY WITH EFFUSION
David T. Carr, M.D., Rochester, Minn.

R. C. Horn, Jr., M.D.
Detroit, Mich.

S. H. Sturgis, M.D.
Boston, Mass.

Mr. H. W. Ginty
Fort Wayne, Ind.

H. L. Israel, M.D.
Philadelphia, Pa.

D. B. Radner, M.D.
Chicago, Ill.

D. T. Carr, M.D.
Rochester, Minn.

4:05—PANEL ON PLEURAL DISEASE
Moderator: David T. Carr, M.D., Rochester, Minn.
Participants: **Harold Israel, M.D.**, Philadelphia, Pa.; **Donald Stevenson, M.D.**, Madison; **Helen A. Dickie, M.D.**, Madison; **D. B. Radner, M.D.**, Chicago, Ill.; **Ben R. Lawton, M.D.**, Marshfield

II. OBSTETRICS AND GYNECOLOGY

JUNEAU HALL—Milwaukee Auditorium

Moderator: David J. Werner, M.D., Milwaukee

2:00—PROPHYLAXIS IN GYNECOLOGY
Edwin J. DeCosta, M.D., Chicago, Ill.

2:30—POLYCYSTIC OVARY SYNDROME
Somers H. Sturgis, M.D., Boston, Mass.

3:00—Recess to View Exhibits

3:45—Panel on GYNECOLOGIC ENDOCRINOLOGY
Moderator: David J. Werner, M.D., Milwaukee
Participants: **Edwin J. DeCosta, M.D.**, Chicago, Ill.
Somers H. Sturgis, M.D., Boston, Mass.

4:30—Business Meeting of Wisconsin Society of Obstetrics and Gynecology

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* *Planned in Cooperation with the Wisconsin Society of Internal Medicine and the Wisconsin Chapter of the American College of Chest Physicians.*

TUESDAY, MAY 2 continued

III. PATHOLOGY

ENGELMANN HALL—Milwaukee Auditorium

Moderator: David J. Carlson, M.D., Milwaukee

2:00—THE HISTOPATHOLOGY OF THYROID DYSFUNCTION

Robert C. Horn, Jr., M.D., Detroit, Mich.

2:30—LABORATORY DIAGNOSIS OF THYROID DISEASE

Robert J. Fink, M.D., Eau Claire

3:00—Recess to View Exhibits

3:45—DIAGNOSTIC AND THERAPEUTIC CLINIC WITH CASE PRESENTATIONS

Coordinator: David J. Carlson, M.D., Milwaukee

Special Consultant: **Robert C. Horn, Jr., M.D.,** Detroit, Mich.

IV. PSYCHIATRY

KILBOURN HALL—Milwaukee Auditorium

Moderator: Gilbert B. Tybring, M.D., Madison

2:00—SPECIAL LEGAL ASPECTS OF PSYCHIATRIC TREATMENT

Mr. Harry W. Ginty, Vice-president, The Medical Protective Co., Fort Wayne, Ind.

2:45—DISCUSSION

3:00—Recess to View Exhibits

3:45—Panel on TRAUMATIC NEUROSIS

Moderator: Gilbert B. Tybring, M.D., Madison

Participants: **William H. Heywood, M.D.,** Marshfield; **Francis J. Millen, M.D.,** Milwaukee; **Mr. Ralph E. Gintz,** Director, Workmen's Compensation Division, Wisconsin Industrial Commisson, Madison

8:00 P.M.—FIRESIDE CONFERENCES

EAST ROOM—Hotel Schroeder

Hosts: John Rankin, M.D., Madison; Armin R. Baier, M. D.; and Raymond R. Watson, M.D., Milwaukee

1. **CARDIAC ARRHYTHMIAS**
   Herman H. Shapiro, M.D., Madison; **Howard L. Correll, M.D.,** Milwaukee; **Sydney T. Gettelman, M.D.,** Milwaukee; and **Nathan Grossman, M.D.,** Milwaukee
2. **PLEURAL DISEASE**
   David T. Carr, M.D., Rochester; **William J. Blake, M.D.,** Milwaukee; and **Donald E. Koepke, M.D.,** Madison
3. **PULMONARY MANIFESTATIONS OF SYSTEMIC DISEASE**
   Harold T. Israel, M.D., Philadelphia; **Helen A. Dickie, M.D.,** Madison; and **Julius M. Meyer, M.D.,** Milwaukee
4. **BRONCHIAL ASTHMA**
   D. B. Radner, M.D., Chicago; **A. J. Sosman, M.D.,** Milwaukee; **John R. Talbot, M.D.,** Madison, and **John A. Arkins, M.D.,** Milwaukee
5. **PULMONARY EMPHYSEMA**
   Walter H. Thiede, M.D., Milwaukee; **Nola M. Moore, M.D.,** Madison; and **Leon H. Hirsh, M.D.,** Milwaukee
6. **CARDIOVASCULAR SURGERY**
   William P. Young, M.D., Madison; **Albert H. Pemberton, M.D.,** Milwaukee; and **William J. Gallen, M.D.,** Milwaukee
7. **X-RAY DIAGNOSIS OF LUNG DISEASE**
   John H. Juhl, M.D., Madison; **Jerome L. Marks, M.D.,** Milwaukee; **Richard P. Jahn, M.D.,** Milwaukee; **Charles Schmidt, M.D.,** Milwaukee; and **George H. Jurgens, M.D.,** Milwaukee
8. **OCCUPATIONAL LUNG DISEASE**
   Elston L. Belknap, M.D., Milwaukee; **Oscar A. Sander, M.D.,** Milwaukee; and **Paul J. Whittaker, M.D.,** Milwaukee
9. **TREATMENT OF PULMONARY INFECTIONS**
   Burton A. Waisbren, M.D., Milwaukee; and **John H. Flinn, M.D.,** Madison
10. **SPECIAL METHODS FOR THE DIAGNOSIS AND STUDY OF LUNG DISEASE**
    Hollis G. Boren, M.D., Houston; and **John T. Pellett, M.D.,** Madison
11. **CARDIAC REHABILITATION**
    George A. Hellmuth, M.D., Milwaukee; **William V. Baker, M.D.,** Milwaukee; **Robert W. Boyle, M.D.,** Milwaukee; and **Robin N. Allin, M.D.,** Madison

These informal conferences are open to all physicians. Guests are invited to bring their interesting or puzzling x-rays, EKGs and clinical problems for discussion.

Wednesday—May 3

9:00 A.M.—EXHIBITS

SPECIAL LECTURE PROGRAMS

I. INTERNAL MEDICINE *(9:00 A.M.)

ENGELMANN HALL—Milwaukee Auditorium

Moderator: Ross Kory, M.D., Milwaukee

9:00—HAIRSPRAY PNEUMONITIS

R. C. Buxbaum, M.D., Madison

9:15—CAVITARY PULMONARY DISEASE FOLLOWING EMBOLI

Allan Kind, M.D., Marshfield

9:30—Panel on PULMONARY EMBOLISM AND INFARCTION

Moderator: Harold Israel, M.D., Philadelphia

Participants: **D. B. Radner, M.D.,** Chicago, Ill.; **David T. Carr, M.D.,** Rochester, Minn.; **James M. Sullivan, M.D.,** Milwaukee

10:15—Recess to View Exhibits

10:30—ETIOLOGY AND PATHOGENESIS OF PULMONARY EMPHYSEMA

Hollis G. Boren, M.D., Houston, Tex.

11:00—DIAGNOSIS OF LOCALIZED PULMONARY DISEASE

(An hour's discussion of case presentations: "Stump the Experts!")

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* *Planned in Cooperation with the Wisconsin Society of Internal Medicine and the Wisconsin Chapter of the American College of Chest Physicians.*

Moderator: John Rankin, M.D., Madison
Participants: **Walter H. Jaeschke, M.D.**, Madison; **John R. Pellett, M.D.**, Madison; **John H. Juhl, M.D.**, Madison; **Harold Israel, M.D.**, Philadelphia, Pa.; **David T. Carr, M.D.**, Rochester, Minn.; **Hollis G. Boren, M.D.**, Houston, Tex.

II. GENERAL PRACTICE (10:00 A.M.)

PLANKINTON HALL—Milwaukee Auditorium

(Program arranged in cooperation with Wisconsin Academy of General Practice, and provides 6 hours of Category I credit for A.A.G.P. members in attendance at both morning and afternoon programs.)

Moderator: Robert E. Callan, M.D., Milwaukee

10:00—**RECOGNITION OF THE AEROPHAGIC SYNDROMES**
J. L. A. Roth, M.D., Philadelphia, Pa.

10:30—**TUMORS IN CHILDHOOD**
Tague Chisholm, M.D., Minneapolis, Minn.

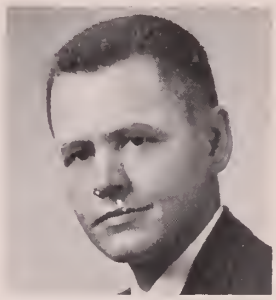
11:00—**CANCER RESEARCH IN RUSSIA AND THE UNITED STATES**
J. R. Heller, M.D., New York City
(Lecture provided by Cancer Division, Wisconsin State Board of Health)

11:30—**HEAD INJURIES IN INFANCY AND CHILDHOOD**
Richard C. Schneider, M.D., Detroit, Mich.

12:15 P.M.—SCIENTIFIC LUNCHEONS

(See reservation form on page 238)
HOTEL SCHROEDER

1. **POST-CHOLECYSTECTOMY SYNDROME**
J. L. A. Roth, M.D., Philadelphia, Pa.
Moderator: M. C. F. Lindert, M.D., Milwaukee
EAST ROOM—5th FLOOR
2. **THE SURGICAL TREATMENT OF THE HYPERTROPHIC ARTHRITIC PATIENT WITH NEUROLOGICAL SIGNS AND SYMPTOMS**
Richard C. Schneider, M.D., Detroit, Mich.
Moderator: James E. Miller, M.D., Madison
ENGLISH ROOM—5th FLOOR
3. **INTESTINAL OBSTRUCTION IN NEWBORN INFANTS**
Tague Chisholm, M.D., Minneapolis, Minn.
Moderator: Marvin Glicklich, M.D., Milwaukee
ROOM 507—5th FLOOR
4. **DIFFERENTIAL DIAGNOSIS OF ASTHMA IN CHILDHOOD**
George B. Logan, M.D., Rochester, Minn.
Moderator: Harry R. Weil, M.D.
ROOM 508—5th FLOOR
(Business Meeting of Wis. Allergy Society members attending luncheon, at 1:45 p.m.)
5. **WHAT CAN BE DONE TO REDUCE THE TOLL OF OUR SECOND CAUSE OF DEATH?**
J. R. Heller, M.D., New York City
Moderator: Carl N. Neupert, M.D., Madison
PARLOR A—4th FLOOR
6. **ITCHING**
Sture A. M. Johnson, M.D., Madison
PARLOR C—4th FLOOR
7. **ANESTHETIC PROBLEMS OF THE SMALL HOSPITAL**
Jay J. Jacoby, M.D., Milwaukee
PARLOR D—4th FLOOR
8. **INDUCTION OF LABOR**
M. Edward Davis, M.D., Chicago, Ill.
Moderator: M. Alex Krembs, M.D., Milwaukee
PARLOR E—4th FLOOR
9. **OFFICE PROCTOLOGY**
Robert T. McCarty, M.D., Milwaukee
PARLOR F—4th FLOOR


Tague Chisholm, M.D.
Minneapolis, Minn.

J. R. Heller, M.D.
New York City

SPECIAL LUNCHEONS (Nonscientific)

12:15—**CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION** of the State Medical Society of Wisconsin
PERE MARQUETTE ROOM—5th FLOOR—HOTEL SCHROEDER

12:00—**CLINIC MANAGERS' LUNCHEON**
8th FLOOR—MILWAUKEE ATHLETIC CLUB

2:00 P.M.—SPECIAL PROGRAMS

I. GASTROENTEROLOGY

ENGELMANN HALL—Milwaukee Auditorum
Moderator: M. C. F. Lindert, M.D., Milwaukee

2:00—**INDIVIDUALIZED SELECTION OF ULCER OPERATIONS**
J. L. A. Roth, M.D., Philadelphia, Pa.
(William Beaumont Memorial Lecture)

2:30—**PEPTIC ULCER IN CHILDREN**
Joseph Shaiken, M.D., Milwaukee

2:45—**GASTRIC ULCER—SELECTIVE CONSIDERATIONS**
Jack Levin, M.D., Milwaukee

3:00—**Recess to View Exhibits**

3:45—**DIAGNOSTIC CLINIC OF CASE STUDIES**
Moderator: Irvin M. Becker, M.D., Milwaukee
Participants: **Walton Thomas, M.D.**, Milwaukee; **Robert T. McCarty, M.D.**, Milwaukee; **Harry Kanin, M.D.**, Milwaukee; and **Philip B. O'Neill, M.D.**, Milwaukee
Note: Any physician having a case he wishes discussed, presenting an interesting diagnostic problem in gastroenterology should write Irvin M. Becker, M.D., 425 E. Wisconsin Ave., Milwaukee 2, Wisconsin

WEDNESDAY, MAY 3 continued

II. GENERAL PRACTICE

PLANKINTON HALL—Milwaukee Auditorium

Moderator: A. L. Stahmer, M.D., Wausau

2:00—NEWER DEVELOPMENTS IN CHEMOTHERAPY OF SOLID TUMORS
Fred J. Ansfield, M.D., Madison

2:30—MENSTRUAL IRREGULARITY
M. Edward Davis, M.D., Chicago, Ill.

3:00—Recess to View Exhibits

3:45—COMPLICATIONS OF HYPERTENSION THERAPY
Alan J. Kanter, M. D., Chicago, Ill.
(Lecture sponsored by Wallace Laboratories)

4:15—SAVING THE "HOPELESS" BURN CASES
Sidney K. Wynn, M.D., and **Burton A. Waisbren, M.D.,** Milwaukee

III. ORTHOPEDIC SURGERY

JUNEAU HALL—Milwaukee Auditorium

Moderator: James E. Miller, M.D., Madison

2:00—SERIOUS AND FATAL FOOTBALL INJURIES INVOLVING THE HEAD AND SPINAL CORD
Richard C. Schneider, M.D., Detroit, Mich. (in collaboration with Edward Reifel, M.D., Herbert O. Crisler, S. B., and Bennie G. Oosterbaan, A.B., Ann Arbor, Mich.)

2:45—DISCUSSION

3:00—Recess to View Exhibits

3:45—(Speaker to be announced)

4:15—NEWER TREATMENT OF COMPRESSION FRACTURES
George H. Vogt, M.D., Madison

IV. PEDIATRICS

KILBOURN HALL—Milwaukee Auditorium

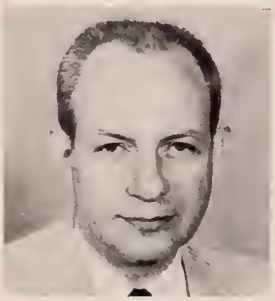
Moderator: James P. Conway, M.D., Milwaukee

2:00—THE HERNIA PROBLEM IN PEDIATRICS
Tague Chisholm, M.D., Minneapolis, Minn.

2:30—JAUNDICE IN THE FIRST YEAR OF LIFE
George B. Logan, M.D., Rochester, Minn.

3:00—Recess to View Exhibits

3:45—PEDIATRIC CLINIC
Staff of Milwaukee Children's Hospital
(Cases in areas of pediatric surgery and pediatric allergy will be presented for discussion)



R. C. Schneider, M.D.
Detroit, Mich.

G. B. Logan, M.D.
Rochester, Minn.

M. E. Davis, M.D.
Chicago, Ill.

K. L. Roper, M.D.
Chicago, Ill.

Thursday—May 4

9:00 A.M.—EXHIBITS

BRUCE HALL—Milwaukee Auditorium

Exhibits open for study of scientific and technical displays.

10:00 A.M.—GENERAL SCIENTIFIC SESSION

PLANKINTON HALL—Milwaukee Auditorium

Moderator: M. C. F. Lindert, M.D., Milwaukee

10:00—DOES YOUR PATIENT "NEED" A PSYCHIATRIST?
Eugene S. Turrell, M.D., Milwaukee

10:30—EVALUATION AND MANAGEMENT OF EYE PROBLEMS COMMONLY ENCOUNTERED IN GENERAL PRACTICE
Kenneth L. Roper, M.D., Chicago, Ill.

11:00—THE RECOGNITION AND TREATMENT OF HEART FAILURE IN THE OPERATING ROOM
Kenneth K. Keown, M.D., Columbia, Mo.

11:30—FUNDAMENTALS OF ROENTGEN DIAGNOSIS OF THE ACUTE ABDOMEN
Benjamin Felson, M.D., Cincinnati, Ohio

THURSDAY MAY 4 continued

12:15 P.M.—SCIENTIFIC LUNCHEONS

(See reservation form on page 238)

HOTEL SCHROEDER

1. **SURGICAL ASPECTS OF ALIMENTARY TRACT CANCER**
   Owen Wangensteen, M.D., Minneapolis, Minn.
   Moderator: A. R. Curreri, M.D., Madison
   PERE MARQUETTE ROOM—5th FLOOR
2. **SPLENOPORTOGRAPHY**
   Benjamin Felson, M.D., Cincinnati, Ohio
   Moderator: F. F. Golden, M.D., Madison
   ENGLISH ROOM—5TH FLOOR
3. **ARRHYTHMIAS ASSOCIATED WITH ANESTHESIA**
   Kenneth K. Keown, M.D., Columbia, Mo.
   Moderator: George C. Kreuter, M.D., Milwaukee
   ROOM 507—5th FLOOR
4. **UTERINE BLEEDING—TOO MUCH AND TOO LITTLE**
   Ben M. Peckham, M.D., and **William Kiekhofer, M.D.,** Madison
   ROOM 508—5th FLOOR
5. **E.E.N.T. LUNCHEON**
   (No luncheon speaker, but program begins immediately following lunch. See details of program below)
   EAST ROOM—5th FLOOR
6. **MANAGEMENT OF RESISTANT CONGESTIVE HEART FAILURE**
   Francis D. Murphy, M.D., Milwaukee
   PARLOR A—4th FLOOR
7. **NOTHING ON BURNS**
   George E. Collentine, Jr., M.D., John D. Conway, M.D., and **Walter J. Woloschek, M.D.,** Milwaukee
   PARLOR C—4th FLOOR

SPECIAL LUNCHEONS (Nonscientific)

12:15—PAST PRESIDENT'S LUNCHEON
PARLOR G—4th FLOOR—Hotel Schroeder

1:00 P.M.—SPECIAL PROGRAMS

I. OPHTHALMOLOGY & OTOLARYNGOLOGY

EAST ROOM (5th floor)—Hotel Schroeder

Moderator: Clemens G. Kirchgeorg, M.D., Neenah

1:00—BUSINESS MEETING

2:00—THE CATARACT OPERATION: A STUDY OF DETAILS
Kenneth L. Roper, M.D., Chicago, Ill.

2:45—SURGERY FOR HEARING IMPAIRMENT
Jerome A. Hilger, M.D., St. Paul, Minn.

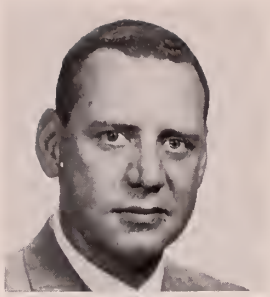
3:15—DISEASES OF THE LARYNX: DIAGNOSIS AND TREATMENT
Charles J. Finn, M.D., Milwaukee

2:00 P.M.—SPECIAL PROGRAMS

I. ANESTHESIOLOGY

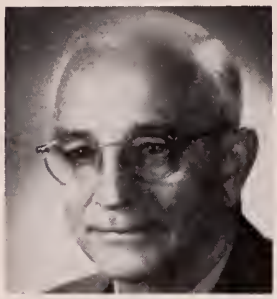
ENGELMANN HALL—Milwaukee Auditorium

Moderator: George C. Kreuter, M.D., Milwaukee

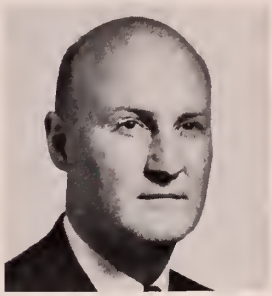


Kenneth Keown, M.D.
Columbia, Mo.

Benjamin Felson, M.D.
Cincinnati, Ohio



O. H. Wangensteen, M.D.
Minneapolis, Minn.



Jerome Hilger, M.D.
St. Paul, Minn.

F. H. Van Bergen, M.D.
Minneapolis, Minn.

G. D. Davis, M.D.
Rochester, Minn.

2:00—PULMONARY HYPERTENSION
Frederick Van Bergen, M.D., Minneapolis, Minn.

2:30—ANESTHESIA FOR INTRACARDIAC SURGERY
Kenneth K. Keown, M.D., Columbia, Mo.

3:00—Recess to View Exhibits

3:45—ALTERED BLOOD VOLUME IN SURGICALLY CONTRACTABLE HEART DISEASE
Robert A. Schmidt, M.D., Milwaukee

4:15—PULMONARY FUNCTION STUDIES AFTER OPEN HEART SURGERY
Carl W. Schmidt, M.D., and **Karl Siebecker, M.D.,** Madison

4:30—A REVIEW OF THE CURRENT STATUS OF CARDIAC RESUSCITATION
Kenneth C. Leenhouts, M.D., Waukesha

5:00—BUSINESS MEETING
Wisconsin Society of Anesthesiologists

II. RADIOLOGY

WALKER HALL—Milwaukee Auditorium

Moderator: F. F. Golden, M.D., Madison

2:00—**FILM-READING SESSION AS A TEACHING TECHNIQUE**
Benjamin Felson, M.D., Cincinnati, Ohio

2:30—**ENDOCARDIAL FIBROELASTOSIS**
Donald P. Babbitt, M.D., Milwaukee

2:45—**AIR CONTRAST STUDY OF THE COLON**
Theodore Glaessner, M.D., Milwaukee

3:00—**Recess to View Exhibits**

3:45—**ROENTGENOLOGIC CONTRIBUTIONS IN THE STUDY OF RENAL HYPERTENSION**
George D. Davis, M.D., Rochester, Minn.

4:15—**A NEW X-RAY DOSIMETER**
John Cameron, Ph.D., Madison

4:30—**BUSINESS SESSION**
Section on Radiology

4:45—**BUSINESS SESSION**
Executive Committee, Wisconsin Radiological Society

7:00—**DINNER, Wisconsin Radiological Society**
Members Only, University Club (Reservations through Robert Byrne, Columbia Hospital, Milwaukee 11)

Speaker: **George D. Davis, M.D.,** Rochester, Minn.
Subject: **POSTBULBAR DUODENAL ULCER**

III. SURGERY*

PLANKINTON HALL—Milwaukee Auditorium
Moderator: Peter Midelfart, M.D., Eau Claire

2:15—**INTERMITTENT PYLORIC OBSTRUCTION DUE TO MASSIVE GRANULOMA OF THE STOMACH**
Kendall E. Sauter, M.D., Milwaukee

2:30—**CLINICAL SIGNIFICANCE OF PROLAPSED HYPERTROPHIED GASTRIC MUCOSA**
Louis Olsman, M.D., Kenosha

E. J. DeCosta, M.D.
Chicago, Ill.

J. L. A. Roth, M.D.
Philadelphia, Pa.

2:45—**GASTROINTESTINAL INTUBATION**
Owen H. Wangensteen, M.D., Minneapolis, Minn.
(Erastus B. Wolcott Memorial Lecture)

3:15—**Recess to View Exhibits**

3:30—**THE DILEMMAS OF CLINICAL SURGERY**
Address of Incoming President
J. A. Killins, M.D., Green Bay

3:45—**PANCREATIC PSEUDOCYSTS, FOLLOW-UP RESULTS OF INTERNAL DRAINAGE**
John D. Hurley, M.D., Milwaukee

4:00—**THE CHOICE OF OPERATION FOR DUODENAL ULCER**
Kenneth A. Seifert, M.D., Wauwatosa

4:15—**TUBE DUODENOSTOMY**
A. D. Anderson, M.D., Madison; and **Harold Fromm, M.D.,** Madison

4:30—**ANNUAL BUSINESS MEETING**
Wisconsin Surgical Society (members only)

7:00—**SOCIAL HOUR AND DINNER, Wisconsin Surgical Society**
(Restricted to members only, wives invited, informal, ticket only)

Guest speaker to be announced
MILANO ROOM—Milwaukee Athletic Club

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* *Morning program of Wisconsin Surgical Society at Children's Hospital. Details of program sent all members.*

Faculty Lecturers

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL, Madison

F. J. ANSFIELD, M.D.: Assist. Prof., Cancer Research Hosp.

J. H. BARBOUR, M.D.: Assist. Prof., Anesthes.

J. Z. BOWERS, M.D.: Dean, Med. School; Prof., Medicine

H. A. DICKIE, M.D.: Prof., Medicine

J. H. FLINN, M.D.: Assist. Prof., Medicine; Dir., Student Health

W. H. JAESCHKE, M.D.: Prof., Medicine (Clin. Path.), Dir. Lab. Surgical Path.

S. A. M. JOHNSON, M.D.: Prof., Medicine (Dermatology)

J. H. JUHL, M.D.: Assoc. Prof. Radiol.

Wm. KIEKHOFER, M.D.: Assist. Prof., Obstetrics & Gynecology

G. C. MUELLER, M.D.: Prof., Oncology

B. M. PECKHAM, M.D.: Prof. & Chrm., Ob. & Gyn.

J. R. PELLETT, M.D.: Proj. Assoc., Cancer Res. Hosp.

K. L. SIEBECKER, M.D.: Assoc. Prof. Anesth.

A. A. SIEBENS, M.D.: Assoc. Prof., Pediatrics; Med. Dir., Respiratory & Rehabilitation Center

G. H. VOGT, M.D.: Clin. Instr., Orthopedic Surgery

W. P. YOUNG, M.D.: Assoc. Prof., Surgery

C. W. COTTERMAN, Ph.D.: Prof., Medicine (Genetics)

MARQUETTE UNIVERSITY SCHOOL OF MEDICINE, Milwaukee

D. P. BABBITT, M.D.: Clin. Instr., Radiology

L. G. CAREY, M.D.: Assist. Instr., Surgery

G. E. COLLENTINE, JR., M.D.: Assist. Clin. Prof., Surgery

C. J. FINN, M.D.: Assist. Clin. Prof., Otolaryngology

DONALD GREIFF, Sc.D.: Prof., Pathology

J. D. HURLEY, M.D.: Assist. Prof., Surgery

J. J. JACOBY, M.D.: Prof. & Chrm., Anesthesiology

H. J. KANIN, M.D.: Asst. Clin. Prof., Medicine

J. J. LEVIN, M.D.: Assoc. Prof., Medicine

R. T. McCARTY, M.D.: Assoc. Clin. Prof., Surgery

F. J. MILLEN, M.D.: Assoc. Clin. Prof., Neurology

F. D. MURPHY, M.D.: Clin. Prof., Medicine

P. B. O'NEILL, M.D.: Clin. Instructor, Medicine

A. J. QUICK, M.D.: Prof. & Chrm., Biochemistry

R. A. SCHMIDT, M.D.: Clin. Instr., Anesthes.

J. SHAIKEN, M.D.: Assoc. Clin. Prof., Medicine

J. M. SULLIVAN, M.D.: Assoc. Clin. Prof., Surgery

W. D. THOMAS, M.D.: Asst. Clin. Prof., Surgery

E. S. TURRELL, M.D.: Prof. & Chrm., Psychiatry

B. A. WAISBREN, M.D.: Assist. Clin. Prof., Medicine

W. WEISEL, M.D.: Assoc. Clin. Prof., Surgery

W. J. WOLOSCHEK, M.D.: Clin. Instr., Surgery

S. K. WYNN, M.D.: Assist. Clin. Prof., Plastic & Reconstructive Surgery

Annual Dinner

WEDNESDAY—MAY 3

BALLROOM—HOTEL SCHROEDER

RECEPTION: 6:15 DINNER: 7:15

Fun and Informal! With direction from President Sorenson a new approach to the Annual Meeting program has been developed so that a lighter, more informal atmosphere will prevail. Highlight of the program will be a musical comedy skit. There will be no major speech for the evening.

Music: Steve Swedish and his Band.

Dancing: During Dinner and from 10:00 p.m. to 11:30 p.m.

Light Entertainment: A clever and tuneful skit.

"MY FAIR SURGEON"

Music by two well-known figures:
Lerner & Lowe!
Lyrics by a "sleeper":
Frank J. Cerny, M.D., Fond du Lac

A really high class satire on "My Fair Lady" which has a medical theme. Produced and performed by members of the Woman's Auxiliary to the Fond du Lac County Medical Society.

Starring: *Mrs. James Habermann*, Denver (Formerly of Fond du Lac . . . whom we are flying in for the occasion!)

Left to right: Mrs. Hans Hagel, Mrs. Howard Mauthe, Mrs. L. J. Keenan, and Mrs. R. W. Schroeder.

Make up a party and join in on the fun . . . this will be a time for relaxation and laughter! $7.00 per person (including refreshments at President's Reception). A bargain, so bring along your wife and make your reservations at the same time you make reservations for noon luncheons.

Scientific Exhibits

MILWAUKEE AUDITORIUM

Important

Because of the great interest shown in Scientific Exhibits additional space has been provided in South Kilbourn and North Juneau Halls, to supplement the exhibits displayed in Bruce Hall. You are urged to view *all* of the scientific exhibits displayed in these three areas.

EXHIBITS IN BRUCE HALL

18–19—EXHIBITS OF EVANGELICAL DEACONESS HOSPITAL, MILWAUKEE

1. THE USE OF REGIONAL HEPARINIZATION DURING HEMODIALYSIS WITH THE KOLFF ARTIFICIAL KIDNEY

Drs. A. L. Settimi, J. Means, J. Sullivan, R. Herrington, R. Haukohl, and Y. Taira

In certain clinical states associated with bleeding tendencies it is desirable to neutralize the heparin, which is necessary in the extracorporeal circuit, before it returns to the patient.

The technique consists of introduction of heparin into the inflow side of the Kidney, the dosage being precomputed, and injected at a constant rate. At the outflow side of the Kidney this quantity of heparin is neutralized with a constant rate infusion of polybrene. In this way the blood of the patient retains normal coagulation properties.

Dosage of heparin and Polybrene are monitored by appropriately timed heparin assays and coagulation times.

The exhibit consists of demonstrations of the Harvard Apparatus in use, the Kolff Apparatus, charts of typical values of drug administration, and heparin assay values.

2. ADENOMYOSIS OF THE UTERUS

Drs. Edgar Habeck and Dean Spyres

The exhibit graphically illustrates the pathology involved and the variations encountered. Symptomatology and diagnostic points which the practitioner may utilize are derived from a large series of cases analyzed and treated.

47–48—PATHOLOGY OF MAJOR PULMONARY DISEASES AS DEMONSTRATED BY FUME FIXATION

Hollis G. Boren, M.D., and Associates, VA Hospital, Houston, Tex.

49A–49—LOCALIZATION OF VASCULAR BRAIN LESIONS BY CLINICAL SIGNS

Physical Medicine & Rehabilitation Service, VAC, Wood; Department of Physical Medicine and Rehabilitation, Marquette University School of Medicine; and Division on Rehabilitation, Commission on State Departments of the State Medical Society.

The exhibit is centered around an artist's illustration of the brain, with 8 graphic panels showing the most common sites of vascular lesions. There will also be 8 angiograms, illustrating these common sites.

50—THE RADIOISOTOPE RENOGRAM

Radioisotope Service of Veterans Administration Center, Wood

The use of radioisotopes to study individual kidney function by external body counting is demonstrated. This includes large photos of equipment in operation, and several actual renograms to demonstrate normal and abnormal kidney function. The use of the excretion rate to determine total kidney function is illustrated. Case studies accompany some abnormal renograms, and correlation with other kidney function tests is shown.

75–76A—ASSOCIATED EXHIBITS OF ST. JOSEPH'S HOSPITAL, MILWAUKEE

1. ABNORMAL PYRIDOXINE METABOLISM IN TOXEMIA OF PREGNANCY

Drs. J. A. Klieger, J. Evrard, and Messrs. Rex Pierce and A. Skadulis

In recent years there has been a growing impression that there is a functioning derangement of Vit. B6 metabolism in toxemia of pregnancy. Evidence supporting this contention is based on the response of toxemic patients to a tryptophane load and/or pyridoxine ingestion. Exact knowledge of the pyridoxine content of various tissues by microbiological assay, be helpful in determining which of these various theoretical pathognomonic modes is responsible for this deficiency. The authors determined the pyridoxine content of various tissues by microbiological assay, and also plotted their pyridoxine ellution patterns. Techniques and results are shown in the exhibit.

2. NECROTIZING PAPILLITIS—ROENTGEN FINDINGS

Drs. Arthur Fitz, James Lee, J. F. Wepfer, G. W. Sengpiel

Necrosis of the renal papillae occurs most frequently as a complication in patients with diabetes mellitus and acute pyelonephritis. Less frequently it occurs with obstruction uropathy. The diagnosis is generally established postmortem, although during the past few years a number of reports have been recorded describing recognition during the patients lifetime. The purpose of this exhibit is to demonstrate the pertinent roentgen findings as well as the differential diagnosis.

3. SOME RECENT ADVANCES IN CLINICAL LABORATORY AND MEDICINE

Drs. John Bareta, Chas. Altshuler, and Sister M. Verona, O.S.F.

The exhibit illustrates the determination of plasma pigments in serum in instances of hemolytic disease, immunoelectrophoresis, serum fluorescent antibody techniques, microchemical analyses, paper and column chromatography, spectrophotofluorometry and several isotope procedures.

101—PATHOGENESIS OF ATHEROSCLEROSIS

A. M. Evans, M. D., Milwaukee Hospital, and K. D. Brown, Ph.D., Veterans Administration Center, Wood

A schematic representation of the stepwise development of the atherosclerotic vascular plaque is presented, along with supporting experimental and clinical data.

Various points where the pathogenic development of such a plaque might be influenced are delineated. Clinical results from efforts to modify factors identified with atherosclerogenesis are presented. It is suggested that arteriosclerosis might be best influenced at an early and reversible point by recognizing and modifying factors known to accelerate this disease before clear-cut clinical evidence of the disease itself becomes manifest.

The material offered for exhibit is drawn both from animal work on experimental arteriosclerosis and well-controlled human material exhibiting one or more "atherogenic" tendencies.

104—RADIOGRAPHY OF THE BREAST

Charles E. Schmidt, M.D., St. Luke's Hospital, Milwaukee

The exhibit will show soft tissue x-rays of the breast, showing both benign and malignant lesions. A summary of indications and accuracy will be presented.

105—LUNG BIOPSY AS A DIAGNOSTIC AID IN CASES OF DIFFUSE PULMONARY FIBROSIS

Drs. R. Watson, W. Thiede, and W. Blake, Depts. of Surgery, Internal Medicine, and Pathology, St. Luke's Hospital, Milwaukee

The exhibit will consist of a facade, or face-board, with case histories and other inscription centered about various sized illuminated transparencies illustrating the subject matter. The exhibit is essentially a clinicopathologic correlative study.

102-3—DEVELOPMENTAL EVALUATION OF THE INFANT IN THE FIRST FOUR MONTHS OF LIFE

Lucille B. Glicklich, M.D., Milwaukee Children's Hospital

The exhibit emphasizes the technique of examination and the reflex response of the infant during the first four months of life, for the purpose of promoting early recognition of abnormal neurological findings. This will be accomplished by use of photographs and drawings of various reflexes of the neonate, and the author will be in attendance to discuss the exhibit with those who view it.

106-7—APPROACHES TO CANCER CHEMOTHERAPY

J. D. Hurley, M.D., Dept. of Surgery, Milwaukee County Hospital

A panorama of methods of application of presently available tumor chemotherapy approaches is graphically demonstrated. Methods of systemic administration, including intravascular, intraserous cavitary and intratumor techniques are outlined and described. Approaches to regional therapy by means of intra-arterial injections and the isolated perfusion technique are similarly graphically portrayed. The limitations, complications and hazards of cancer chemotherapy are discussed and reviewed, with end results of therapy presented.

Dr. A. R. Curreri
Chairman, Scientific Exhibits

108—GROSS TISSUE DEMONSTRATIONS

Section on Pathology, and the Wisconsin Society of Pathologists

Gross specimens will be shown, with demonstrators present to discuss clinicopathologic correlation.

109—POLYPS OF THE LARGE INTESTINE

Drs. A. C. Gorder, R. R. Byrne, and R. R. Koenig, Columbia Hospital, Milwaukee

The clinical, radiological, and pathologic aspects of single and multiple polyps of the colon and rectum are considered, with discussion of diagnosis, prognosis and treatment in various locations. Case reports illustrate the pertinent points.

110—BLOOD VACCINIA IMMUNE GLOBULIN

Merle Owen Hamel, M.D., Badger Regional Blood Center, Madison

This exhibit shows the development, by the Red Cross Blood Program and the Armed Forces, of Vaccinia Immune Globulin, a blood derivative used in the treatment of complications resulting from smallpox vaccination. Color transparencies show various types of the disease and "before and after" photos. A lighted map shows the location of Blood Centers and points of distribution of the product.

111—A COMPLETE BLOOD BANK SERVICE

T. J. Greenwalt, M.D., and Virginia B. Jefferson, Milwaukee Blood Center, and Committee on Clinical Medicine of the State Medical Society

This exhibit is designed to portray visually how the Milwaukee Blood Center cooperates with 32 affiliated hospitals and the physicians in four counties to meet all blood requirements in the area served: approximately 50,000 transfusion units annually. It shows how donors are received and the blood is processed; and includes pictures of allied services and research activities that are a vital part of the Milwaukee Blood Center's total program. The photographs, taken by an outstanding professional, are displayed according to his specifications and under his supervision. It is the intent to offer a dramatic presentation of a unique medical service, which demonstrates how the medical profession, the hospital council and the community at large can work together to meet a common need.

112—FLUORESCENT MICROSCOPY IN THE DIAGNOSTIC LABORATORY

S. L. Inhorn, M.D., State Laboratory of Hygiene, Madison

The exhibit demonstrates and explains the use of fluorescent techniques in three areas of laboratory diagnosis: (1) rapid identification of pathogenic bacteria and viruses, with special emphasis on the typing of hemolytic streptococcus; (2) an improved and rapid method for demonstrating the L.E.-cell phenomenon; and (3) flourescent stain technique for cancer cytology. The exhibit explains how the Laboratory of Hygiene can be of service to physicians of the state in the areas indicated.

113—THE FUNDUS OF THE EYE IN SYSTEMIC DISEASES

Department of Internal Medicine, St. Francis Hospital, Milwaukee

The exhibit consists of colored drawings and transparencies demonstrating the normal fundus, isolated pathologic changes and typical fundic changes in systemic diseases. The exhibit is meant to orient the physician in normal and pathologic fundic states, thus encouraging the fundoscopic examination as an additional method of diagnosing systemic disease. Written material is also available for distribution.

114—REDUCTION OF SERUM LIPIDS AND OTHER METABOLIC EFFECTS OF NICOTINIC ACID

William B. Parsons, Jr., M.D., Jackson Clinic and Foundation, Madison

Based on the author's experience in the past five years (more than 100 patients treated, with long-term studies in more than 60), the exhibit illustrates the following points: (1) reduction in serum cholesterol and beta lipoprotein cholesterol levels by large doses of nicotinic acid; (2) failure of equal doses of nicotinamide to affect cholesterol levels; (3) a summary of all published studies regarding the mechanism of action of nicotinic acid; (4) illustrations of disappearance of xanthoma tuberosum; (5) incidence of hepatic dysfunction, impaired carbohydrate tolerance and activation of peptic ulcer during prolonged therapy; (6) modification of nicotinic acid preparations to minimize side reactions, and (7) production of fibrinolysin *in vivo* following injection of nicotinic acid. The exhibit includes Kodachrome transparencies, tables and graphs, and thrombelastographic tracings.

EXHIBITS AT FOOT OF STAGE

128—LOCATION OF BLEEDING POINT IN INTESTINAL TRACT WITH RADIOACTIVE TRACERS

Drs. H. Brown, T. Fujino, E. R. Schmidt, and J. Cameron, University Hospitals, Madison

The method described in this exhibit may be considered when conventional methods for locating the site of gastrointestinal hemorrhage have failed. Serum albumin labeled with iodine 131 may be injected into the aorta at the site of the superior mesenteric artery, while the aorta distally is temporarily occluded. If bleeding is vigorous, the part of the bowel hemorrhaging may be found by passing a small probe-type scintillation counter over the bowel to localize a collection of radioactive blood. The method has been used to date only in dogs but should be applicable to patients. The probe and amplifying equipment for detecting radioactivity are displayed along with pictures of the operative technique used. Results are presented graphically.

129—THERAPY IN SKIN INFECTIONS WITH USE OF TRICLOBISONIUM CHLORIDE

William C. Miller, M.D., Wausau

The exhibit depicts, in the form of charts and tables, the author's experience in the treatment of 657 cases of skin infections.

130-31—DERMATOLOGIC PANORAMA: Common and Uncommon Skin Disorders

John J. Sevenants, M.D., La Crosse

By use of a continuous showing of 35 mm. color slides the author depicts a series of common and unusual skin disorders, and their most effective treatment. Either the author or an associate will be in attendance during all recess periods to discuss with those interested the material covered in the slide presentation.

132—AURICULOSTOMY

J. Victor Bolger, M.D., Milwaukee

This exhibit features by photographs and demonstrations the new operation, auriculostomy. A short, 5-minute movie demonstrates the surgical technique of this procedure. A patient with an auriculostomy will be presented.

134—IDENTIFICATION OF HEART SOUNDS

Wisconsin Heart Association

By use of sound tapes of various abnormal heart sounds and murmurs, run through Cambridge equipment and permitting physicians to hear such sounds, the listener will be able to test his ability to detect various types of abnormalities. The sounds will also be visible on an oscilloscope.

HALLWAY LEADING TO MEETING HALLS

135—THORACOTOMY AS A DIAGNOSTIC PROCEDURE

Oscar F. Foseid, M.D., and John H. Morledge, M.D., The Jackson Clinic, Madison

The exhibit will consist of a series of illuminated chest x-rays showing lesions of the lung and chest cavity; beneath each x-ray will be a short history and the findings in each case.

136—CONTROL OF EPISIOTOMY EDEMA AND PAIN WITH ORAL ANTI-INFLAMMATORY ENZYMES

Robert S. Pavlic, M.D., Milwaukee

Since several recent reports indicate that chymotrypsin effectively combats inflammation regardless of site, a study was undertaken to determine its efficacy in episiotomy wound healing. Subjective and objective factors were evaluated in a group of 250 patients who received the investigated drug. This group was compared with a control group of 250 patients. The comparative results are graphically tabulated.

SCIENTIFIC EXHIBITS IN ADJOINING HALLS

IN SOUTH KILBOURN HALL

1-2—A PRACTICAL OFFICE STERILITY WORKUP

B. Kulkoski, M.D. and W. Schibly, M.D., Green Bay

The exhibit consists of five mock-up pelves, each demonstrating a different office procedure in a planned sequence during a sterility workup.

These are supplemented by charts and graphs to explain the procedures. The newer concept of arborization is demonstrated with microscopes and descriptive literature which is made available to the viewer. Newest available methods for pin-pointing ovulation are explained.

3—HEARING AND SPEECH REHABILITATION

Speech and Hearing Rehabilitation Center, Madison

This display is designed to acquaint Wisconsin physicians with services of the Rehabilitation Center in Madison which can be of benefit to their patients experiencing hearing and speech problems. Colored slides will show the various services of the Center, and staff members will be in attendance to discuss these services to physician visitors.

4—STOP ARTHRITIS

Wisconsin Chapter, Arthritis & Rheumatism Foundation

The exhibit illustrates the Foundation's program from the medical man's point of view. The display highlights treatment, research and training, professional education, and special projects.

5—ARTHRITIS AND RHEUMATIC DISORDERS

St. Mary's Arthritis Control Center, St. Mary's Hospital, Milwaukee

The exhibit has two purposes: to demonstrate to physicians the principles of hospital management of arthritis and rheumatic disorders, and how and what to teach the patient who has been hospitalized for rheumatic disorders, to better understand the principles of management and care at home. The exhibit includes charts as to classification, laboratory methods, as well as illustrations of physical and occupational therapy associated with this particular disease. Equipment will be demonstrated and explained by nurses and therapists associated with the Control Center.

6-7-8-9—THE FIRST NEPHRECTOMY

James W. Pick, M.D. and C. R. Marquardt, M.D., Evangelical Deaconess Hospital, Milwaukee

This comprehensive exhibit commemorates the historical work of Doctor Erastus B. Wolcott, who performed a transperitoneal right nephrectomy for hypernephroma on June 4, 1861, the preoperative diagnosis being hepatic cyst. Death from peritonitis followed on the fifteenth postoperative day, at St. Mary's Hospital, Milwaukee, the oldest existent hospital in Wisconsin. This display, which commemorates the work of one of Wisconsin's pioneer surgeons is especially appropriate to present at this time, when the Civil War is being highlighted, since Doctor Wolcott served as Surgeon General of Wisconsin during that period. It is hoped that this valuable historical display will become a permanent part of the Medical Museum in Prairie du Chien.

10—TUBERCULOUS MENINGITIS: Easily Missed . . . . Always a Possibility

Richard P. Jahn, M.D., Wisconsin Anti-Tuberculosis Association

The display depicts the current prevalence of tuberculous meningitis, illustrated by recent cases in Wisconsin. While drugs have completely altered the prognosis of tuberculous meningitis, their effectiveness is limited by late or faulty diagnosis. These facts will be brought out through the use of various exhibit techniques.

NORTH JUNEAU HALL

1—THE DETECTION OF THE PRECLINICAL AND POTENTIAL DIABETIC STATE

Edward H. Tashkin, M.D., Mt. Sinai Hospital, Milwaukee

The exhibit emphasizes (1) the most likely group meriting a screening for diabetes; (2) the tests and their interpretation; (3) the importance of recognizing the prediabetic state in the pregnant woman; and (4) the practical aspects of the problem, in the form of case histories.

2—CAROTID ARTERY INSUFFICIENCY: VARIABLE ETIOLOGICAL FACTORS WITH TAILORED SURGICAL TREATMENT

Marvin Wagner, M.D., Mt. Sinai Hospital, Milwaukee

Three cases of carotid artery insufficiency are featured in the exhibit, each case presenting different etiological factors and each case having a tailored procedure to satisfy the respective situation. Cases illustrated show one with a periodventitial fibrosis of a congenital stenotic internal carotid artery.

3—THE PHYSICIAN'S ROLE IN THE CARE OF THE COLOSTOMY

Milwaukee and Wisconsin Divisions, American Cancer Society

The display will show, by way of slides, how the physician can assist his patient in the care of the colostomy.

4—POISON CONTROL IN WISCONSIN HOSPITALS

Wisconsin Pharmaceutical Association

The Wisconsin Pharmaceutical Association is assisting hospitals in setting up equipment and procedures for the handling of emergency poison cases. The exhibit will outline what is needed in a hospital to provide this community service, and it will indicate how these services can be most effectively employed.

5—ABDOMINAL PREGNANCY

Department of Obstetrics and Gynecology, Mt. Sinai Hospital, Milwaukee

The exhibit will feature diagnosis, pitfalls, and new concepts in the early recognition of abdominal pregnancy.

6—MANAGEMENT OF CONVULSIVE DISORDERS

Drs. E. D. Schwade and J. P. Davis, Mt. Sinai Hospital, and the Variety Club Epilepsy Center

The exhibit will outline what can be done to control various forms of convulsive disorders. Physicians are urged to stop and discuss their problems with the authors, who will be in attendance during recess periods.

7—ROUTINE OPERATIVE CHOLANGIOGRAPHY

R. W. Mann, M.D. and M. E. Sattler, M.D., Mt Sinai Hospital, Milwaukee

The exhibit shows methods at Mt. Sinai Hospital of using operative cholangiography, pointing out technique, advantages, pitfalls, with many examples illustrated in view boxes. The exhibit summarizes experience with 300 cases.

8—PREPYLORIC NARROWING

Drs. M. Moel, L. Mark, N. Enzer, and J. Baron, Mt. Sinai Hospital, Milwaukee

The exhibit contains x-rays and microscopic pathologic photographs and transparencies of approximately eight to ten cases showing x-ray evidence of prepyloric narrowing of both benign and malignant conditions. The exhibit stresses the difficulty in attempting to arrive at a diagnosis and shows criteria to differentiate between malignant and benign lesions. Such conditions as prepyloric and pylorospasm, antral gastritis, benign prepyloric hypertrophy, carcinoma and sarcoma of the antrum are shown. A legend accompanies each case, and the pathologic correlation is shown by photographs or transparencies of the microscopic slides.

9—EARLY DIAGNOSIS OF SLIPPING OF THE CAPITAL EPIPHYSIS

Orthopedic Section, Mt. Sinai Hospital, Milwaukee; J. R. Stone, M.D., Chief

The exhibit shows the methods by which a possible diagnosis can be made, not only by examination of the patient, together with a good history, but also by the early x-ray appearance of the head of the femur. The early diagnosis is stressed, since the end result in these cases is so far superior to that case in which the slipping of the head of the bone is either moderately or far advanced. Age grouping, sex, trauma, and the build of the patient are stressed by the exhibitor.

Technical Exhibits

42—ABBOTT LABORATORIES, North Chicago, Ill.

14—AMERICAN STERILIZER CO., Erie, Pa.

87—AMES COMPANY, Elkhart, Ind.

21—ARMOUR PHARMACEUTICAL CO., Chicago, Ill.

31—AYERST LABORATORIES, Chicago, Ill.

17—ROBERT W. BAIRD CO., Milwaukee

126—BARR X-RAY CO., INC., Milwaukee

64—BENCO OPHTHALMIC LABORATORIES, Milwaukee and La Crosse

40—BENSON OPTICAL COMPANY, Minneapolis, Minn. and Eau Claire

121—GEORGE A. BREON COMPANY, New York City

26—THE BORDEN COMPANY, New York City

30—BROOK HILL FARMS, INC., Chicago, Ill.

44—BROOKS APPLIANCE COMPANY, Chicago, Ill.

65—CHARLES BRUNING CO., INC., Milwaukee

27—BURROUGHS WELLCOME & CO., INC., Tuckahoe, N. Y.

92—CARNATION COMPANY, Los Angeles, Calif.

72—CHICAGO PHARMACAL COMPANY, Chicago, Ill.

70—CIBA PHARMACEUTICAL PRODUCTS, INC., Summit, N. J.

66—DESITIN CHEMICAL COMPANY, Providence, R.I.

122—DICTAPHONE CORPORATION, New York City

36—DIETENE COMPANY, Minneapolis, Minn.

83—DOHO CHEMICAL CORPORATION, New York City

73—EATON LABORATORIES, Norwich, N. Y.

120—ENCYCLOPEDIA AMERICANA, Grand Rapids, Mich.

45—ENCYCLOPEDIA BRITANNICA, Chicago, Ill.

2—ENDO LABORATORIES, INC., Richmond Hill, N. Y.

16—A. J. FARNHAM, COMPANY, Milwaukee

22—H. G. FISCHER & CO., Franklin Park, Ill.

81—FULLER PHARMACEUTICAL CO., Minneapolis, Minn.

59—GEIGY PHARMACEUTICALS, Yonkers, N. Y.

1—GENERAL ELECTRIC CO. (X-Ray DIV.), Milwaukee

28—GERBER PRODUCTS COMPANY, Fremont, Mich.

43—HAUG DRUG COMPANY, Milwaukee

91—HOFFMAN-La ROCHE, INC., Nutley, N.J.

86—HOUSE OF BIDWELL, Milwaukee and Madison

84 & 100—HURLEY X-RAY COMPANY, Milwaukee

20—JOHNSON & JOHNSON, New Brunswick, N. J.

82—C. B. KENDALL COMPANY, Indianapolis, Ind.

29—KNOLL PHARMACEUTICAL COMPANY, Orange, N. J.

4—KREMERS-URBAN COMPANY, Milwaukee

8 & 9—LAKESIDE LABORATORIES, INC., Milwaukee

88 & 89—LANGER LABORATORIES, Milwaukee

74—La SALLE COCA-COLA BOTTLING COMPANY, Milwaukee

3—LEDERLE LABORATORIES, (DIV. OF AM. CYANAMID CO.), Pearl River, N. Y.

41—ELI LILLY & COMPANY, Indianapolis, Ind.

98—LINCOLN LABORATORIES, Decatur, Ill.

10—J. B. LIPPINCOTT COMPANY, Philadelphia, Pa.

25—LLOYD BROTHERS, INC., Cincinnati, Ohio

79—MALTBIE LABORATORIES (DIV. OF WALLACE & TIERNAN, INC.), Belleville, N. J.

85—MARION LABORATORIES, INC., Kansas City, Mo.

35—MARSHALL ERDMAN & ASSOCIATES, Madison

69—S. E. MASSENGILL COMPANY, Bristol, Tenn.

118—MEAD JOHNSON & COMPANY, Evansville, Ind.

51—MEDCO PRODUCTS CO., INC., Tulsa, Okla.

53—THE MEDICAL PROTECTIVE COMPANY, Ft. Wayne, Ind.

115—MEDICO-MART, INC., Milwaukee

55—V. MUELLER & COMPANY, Chicago, Ill.

68—MERCK SHARP & DOHME, Westport, Pa.

63—WILLIAM S. MERRELL COMPANY, Cincinnati, Ohio

15—MILEX-ALPHA PRODUCTS, Evanston, Ill.

97—C. V. MOSBY COMPANY, St. Louis, Mo.
119—JOHN NICHOLS, INC., Milwaukee
46—ORTHOPEDIC APPLIANCE CO., INC., Milwaukee
32—ORTHO PHARMACEUTICAL CORPORATION, Raritan, N. J.
99—PARKE, DAVIS & COMPANY, Detroit, Mich.
94—PENGELLY X-RAY CORPORATION, Milwaukee
125—PFIZER LABORATORIES, Brooklyn, N. Y.
37—PHYSICIANS & HOSPITALS SUPPLY COMPANY, Minneapolis, Minn.
6—PROFESSIONAL BUSINESS SERVICE, La Crosse
13—PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY, Chicago, Ill.
67—REMICRO SCIENTIFIC INSTRUMENT COMPANY, Milwaukee
116—R. J. REYNOLDS TOBACCO COMPANY, Winston-Salem, N. C.
90—RICHARDS MANUFACTURING COMPANY, Memphis, Tenn.
95—RIKER LABORATORIES, INC., Northridge, Calif.
58—A. H. ROBINS COMPANY, INC., Richmond, Va.
124—ROEMER-KARRER COMPANY, Milwaukee
61—J. B. ROERIG & COMPANY, New York City
71—ROSS LABORATORIES, Columbus, Ohio
52—SANBORN COMPANY, Waltham, Mass.
57—SANDOZ PHARMACEUTICALS, Hanover, N. J.
62—W. B. SAUNDERS COMPANY, Philadelphia, Pa.
11—SCHERING CORPORATION, Bloomfield, N. J.
96—SCHIEFFELIN & COMPANY, New York City
12—G. D. SEARLE & COMPANY, Chicago, Ill.
5—SMITH, KLINE & FRENCH LABORATORIES, Philadelphia, Pa.
56—E. R. SQUIBB & SONS, New York City
60—STUART COMPANY, Pasadena, Calif.
117—SWIFT & CO., (BABY FOOD DIV.), Chicago, Ill.
23—THERMO-FAX SALES, INC., Milwaukee and Madison
38—ULMER PHARMACEUTICAL COMPANY, Minneapolis, Minn.
34—THE UPJOHN COMPANY, Kalamazoo, Mich.
80—U. S. STANDARD PRODUCTS COMPANY, Mt. Prospect, Ill.
7—U. S. VITAMIN CORPORATION , New York City
78—WALLACE LABORATORIES, New Brunswick, N.J.
24—WARNER CHILCOTT LABORATORIES, Morris Plains, N. Y.
33—WESTWOOD PHARMACEUTICALS, Buffalo, N. Y.
54—WINTHROP LABORATORIES, New York City
77—WISCONSIN 7-UP DEVELOPERS ASSN., Milwaukee, Madison and Oshkosh
93—ZIMMER MANUFACTURING COMPANY, Warsaw, Ind.

RESERVATION FORMS FOR

Roundtable Luncheons • Annual Dinner

NOTE: Attendance Limited! Please List 3 Choices for each of the days you make reservations. List in order of preference. $2.75 per luncheon, including gratuities.

TUESDAY, MAY 2 (See page 225 for listing)

IMPORTANT: Those making reservations for the Marquette and U. of W. Alumni luncheons please make your reservations as indicated and DO NOT INCLUDE WITH THIS RESERVATION.

1. HORN: HISTOLOGIC DIAG. OF THYROID CANCER
2. STURGIS: TREATMENT OF PRIMARY DYSMENORRHEA
3. GINTY: THE MD AND VIOLATION OF THE LAW

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice: _____

WEDNESDAY, MAY 3 (See page 227 for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. ROTH: POST CHOLECYSTECTOMY SYNDROME
2. SCHNEIDER: THE HYPERTROPHIC ARTHRITIC WITH NEUROLOGICAL SIGNS
3. CHISHOLM: INTESTINAL OBSTRUCTION IN THE NEWBORN
4. LOGAN: DIFFERENTIAL DIAG. OF ASTHMA IN CHILDHOOD
5. HELLER: WHAT CAN BE DONE IN REDUCTION OF CANCER DEATHS
6. JOHNSON: ITCHING
7. JACOBY: ANESTHETIC PROBLEMS OF THE SMALL HOSPITAL
8. DAVIS: INDUCTION OF LABOR
9. McCARTY: OFFICE PROCTOLOGY

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice: _____

THURSDAY, MAY 4 (See page 229 for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. WANGENSTEEN: SURGICAL ASPECTS OF ALIMENTARY TRACT CA
2. FELSON: SPLENOPORTOGRAPHY
3. KEOWN: ARRHYTHMIAS ASSOCIATED WITH ANESTHESIA
4. PECKHAM & KIEKHOFER: UTERINE BLEEDING
5. E.E.N.T. LUNCHEON
6. MURPHY: MANAGEMENT OF RESISTANT CONGESTIVE HEART FAILURE
7. COLLENTINE, CONWAY, & WOLOSCHEK: NOTHING ON BURNS

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice: _____

ANNUAL DINNER, Wed., May 3

DANCING—FLOOR SHOW
SHORT SPEECHES—COCKTAILS

$7.00 PER PERSON (Including Gratuities)

Number Luncheon Tickets ($2.75 each) . . . . . _____ for $_____

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the Wisconsin Medical Journal

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Surgical Treatment of Hemangioma with a Bloodless Field Technique

By SIDNEY K. WYNN, M. D.
Milwaukee, Wisconsin

THE treatment of all hemangiomata revolves around the process of destruction of hemangioma or complete removal of the tumor. Many articles have appeared in the literature of late years regarding spontaneous regression of hemangiomata.

It is true that there are some hemangiomata that probably do regress, especially those of the strawberry birthmark type; however, it is difficult to determine just which of these is going to involute of themselves. The simplicity of surgery in the early stages makes it inadvisable to wait for spontaneous disappearance, since such regression may never come and large growths might develop.

The most common methods of destruction of hemangiomata other than surgery and spontaneous regression are:

1. The use of carbon dioxide snow which destroys the hemangioma by means of actual scar tissue formation within the surface hemangioma.
2. The use of sodium morrhuate injection in which there is a reaction set up causing fibrosis with destruction of hemangioma.
3. The use of radium or x-ray therapy in which one has the actual destruction of hemangioma with scar tissue replacement.

From the standpoint of the least trauma to the infant and parent, time involvement and expense to the patient, hemangiomas are more easily removed with the least late effects if a complete surgical removal can be done.

When methods other than surgical removal are used, inadequacy of destruction is the result most frequently seen (Fig. A and B); secondly, disfigurement with unsightly scars (Fig. C); and thirdly, deformities due to arrested development of underlying osseous structures from irradiation or from scar contractures (Fig. D, E, and F).

Many of us have seen patients with a dead, white-appearing area on the body which has been pronounced cured of heman-

Presented in part at Milwaukee Children's Hospital First Annual Resident Reunion, May 20, 1960.
Doctor Wynn is Assistant Clinical Professor of Plastic and Reconstructive Surgery, Marquette University School of Medicine; Assistant Clinical Professor of Oral Rehabilitation, Marquette University Dental School; Attending Plastic Surgeon, Milwaukee Children's Hospital; Chief of Plastic Surgery, Milwaukee County Hospital; and Chief of Department of Surgery and Section of Plastic Surgery, Mount Sinai Hospital, Milwaukee, Wisconsin.
Medical illustrations by Mr. R. Albertin, Marquette University School of Medicine.

Fig. A—Hemangioma right side of chest, post inadequate injection, x-ray, and radium treatment.

Fig. B—Hemangioma right thigh, five years following carbon dioxide snow therapy. Top skin dead white scar. Hemangioma still present in underlying deep tissues.

gioma. The scar may be as great a cosmetic deformity to the patient as the reddish blue area that was previously present. Here again the patient might have had early surgical removal with less psychic trauma than he experienced from the repeated carbon dioxide snow treatments, and with less expense to the patient.

The late injurious effects of radium therapy result in three important radiobiological effects: (1) chromosomal and may lead to carcinogenesis; (2) results from actual atrophy, loss of function to the cellular elements of the skin and underlying tissues even with the evidence of failure of osseous development; (3) major late complications actually resulting from radiation due to ischemia and necrosis of skin, bone, and any other underlying structures which may be affected, and (4) last of all one should consider the fact that tissues which have had radiation do not tolerate major surgical procedures well and certainly do not tolerate further irradiation. Naturally, the late complications resulting from ischemia and fibrosis will differ with the anatomical location and the degree of injury incurred.

Since the destructive method of treatment of hemangiomata appears to be unsatisfactory in many cases and the removal method by surgery finally deemed necessary, why not consider the surgical removal method the one of choice initially if at all feasible? Many surgeons shy away from the surgical excision of hemangiomata in infants because they fear excessive blood loss. The hemangiomata (especially of the body) which protrude above the surface of the skin also usually have some subcutaneous extension. To do a direct elliptical excision of these areas without provision for shutting off the immediate surrounding deep blood supply, can mean appreciable blood loss in a small infant. A most satisfactory way of providing temporary shut-off of surrounding and deep blood supply can be provided in many cases by the use of a Kocher Light intestinal clamp.

Technique

An elliptical excision is marked with methylene blue (Fig. 1). This is done prior to placing the intestinal clamp because after

the intestinal clamp is placed, the exact location of the incisions may be distorted. The hemangioma is grasped between the fingers and elevated with its surrounding skin. The intestinal clamp is opened with its concave side toward the body. When the clamp is closed, it should be in such a fashion that the elliptical skin markings are still visible above the area of the clamp (Fig. 2, 7 and 9). At times it may be necessary to have an assistant hold this clamp with some pressure at all times downward and another using hooks at each end of the ellipse, pulling the skin upward to prevent the incision areas slipping below the blades of the clamp. When the bloodless field is thus accomplished, incisions are made along the previously marked methylene blue lines. Make sure that the knife, as it goes through the full thickness of skin, is perpendicular to the surface of the skin at the area of the markings. This may mean the knife is almost parallel to the body in some instances (Fig. 3). Following making the skin incisions with complete freeing of the corners, one edge of a small curved scissors is then glided under the dermis at a subcutaneous level to better free the subcutaneous fat along the entire length of the incision on each side of the ellipse (Fig. 4). This will also automatically provide the undermining for the later skin closure.

It then usually is simply a matter of traction upward and backward on a firm-gripping hemostat placed on one end of the ellipse to peel out *in toto* the hemangioma. A combination of blunt finger dissection and scissors spreading may be used below the specimen to facilitate peeling (Fig. 5). Often as the specimen is being peeled out, feeding blood vessels can be identified. These can be clamped and cut above the area and tied off immediately with 0000 plain catgut in spite of the fact that there would be no bleeding while the intestinal clamp is on. This will

Fig. D—Hemangioma left lower eyelid. Fig. E—Same child as in Figure D—14 months following radon seed implantation.

Fig. C—Scar and bald spot deformity resulting from treatment of 1.5 cm. scalp hemangioma. This could have been easily excised and direct closure without hair loss.

Fig. F—Under-developed left zygoma and radiation skin changes in evidence in same patient as Figures D and E 14 years post radon seed implantation.

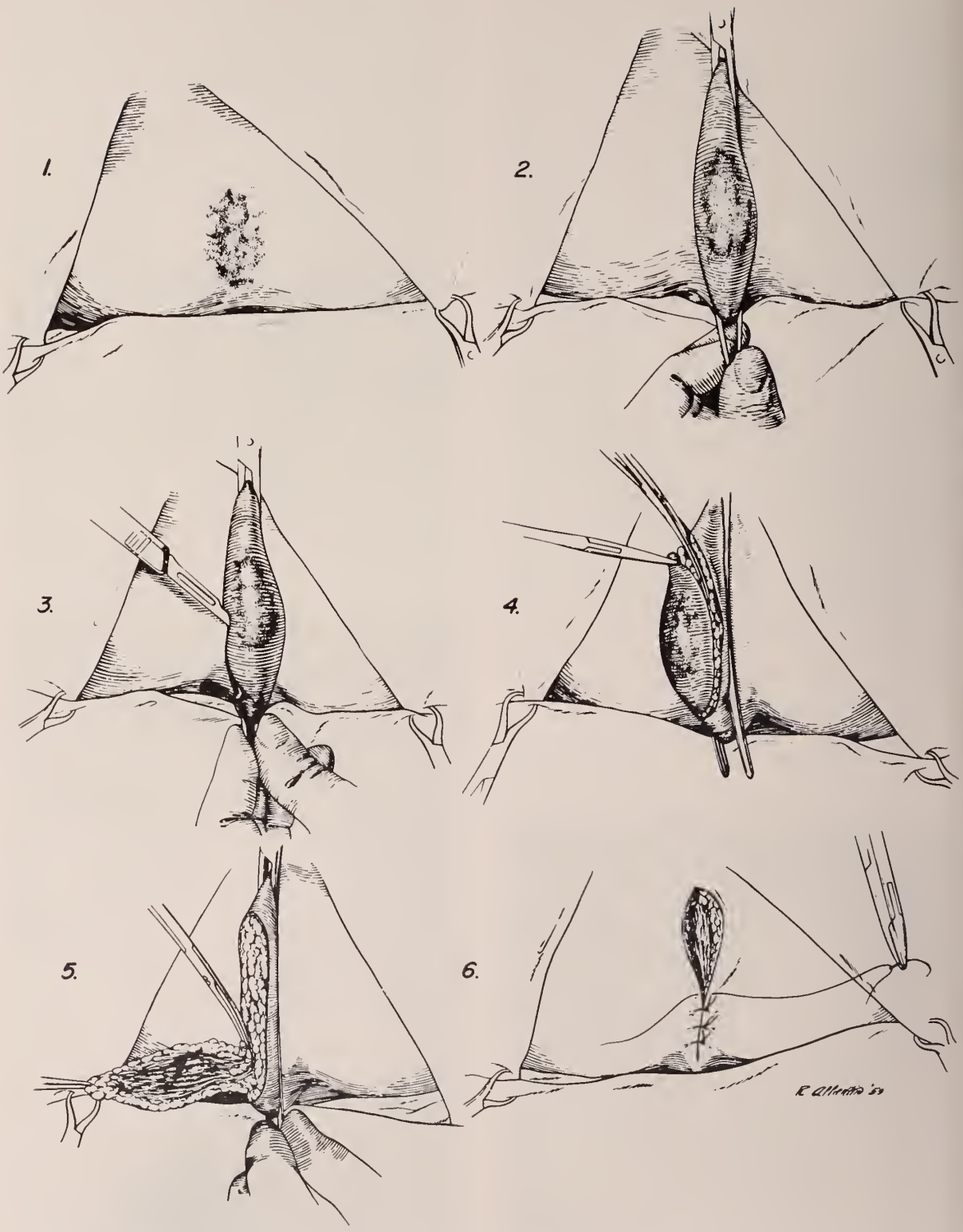

Fig. 1—Methylene blue elliptical markings around surface portion of hemangioma. Fig. 2—Intestinal clamp grasping elevated superficial and deep hemangioma tissue with surrounding skin. Fig. 3—No. 15 blade incising skin at perpendicular angle. Fig. 4—Scissor dissection freeing edges and undermining simultaneously. Fig. 5—Completion of hemangioma removal just before release of intestinal clamp. Fig. 6—Suture of skin defect.

7.

8.

9.

10.

Fig. 7—Hemangioma grasped in intestinal clamp on posterior scalp showing methylene blue elliptical markings. Fig. 8—Interrupted suture used in closure in hair-bearing area. Fig. 9—Hemangioma grasped in intestinal clamp on abdomen showing methylene blue elliptical markings. Fig. 10—Subcuticular suture used for closure in hairless area to avoid suture marks.

save much time later following removal of the intestinal clamp.

The whole procedure of removal in most cases, in view of the bloodless field, takes no more than a few minutes. This probably accounts for the lack of damage to the skin by the intestinal clamp. As soon as the specimen is completely removed, making sure that no deep extensions have been left behind, the clamp is removed and a warm moist sponge is placed in the wound. The remaining bleeders are caught with hemostats and tied off. These are usually minimal if it is the type of hemangioma with definite feeders which were previously caught. A subcutaneous tissue closure is then done with interrupted 000 plain catgut. More undermining can be done if necessary to release skin tension in the larger growths. A subcuticular closure (Fig. 10) is done with 0000 Nylon with an atraumatic needle in exposed areas of the body to cut down on the number of suture marks. In hair-bearing areas continuous or interrupted sutures will suffice (Fig. 6 and 8). An Elastoplast pressure dressing is applied.

Conclusions

A simple method of a practically bloodless removal of a hemangioma is presented. Its simplicity of technique and safety of use for the infant can preclude waiting for many new areas to involute of themselves which some may never do. It also should in many cases supplant the multiple carbon dioxide snow treatments, repeated radium or x-ray therapy, and multiple sclerosing injection methods that are used in many cities on these easily removable localized lesions.

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536 West Wisconsin Avenue.

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Recent Developments in Diuretics

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MEDICINE HAS witnessed many great advances during the past decade and among these, the advances in diuretic therapy have been as brilliant as any. As a result the physician today, in approaching the patient with edema, has at his command a wide array of agents designed to mobilize edema fluid. These agents produce their effects through a variety of pharmacologic mechanisms and, therefore, they can be considered conveniently under the following headings:

1. Agents which interfere with the formation of antidiuretic hormone.
2. Osmotic agents.
3. Acidifying salts.
4. Xanthines and their Derivatives.
5. Cation exchange resins.
6. Carbonic anhydrase inhibitors.
7. Benzothiadiazines.
8. Phthalimidines.
9. Aldosterone antagonists.
10. Organic Mercurials.

Agents Which Inhibit Antidiuretic Hormone

Two agents have been utilized clinically to produce diuresis through the inhibition of the antidiuretic hormone. These include water and ethyl alcohol. Water alone, as a diuretic agent, in conjunction with a low-sodium diet was popularized several years ago by the late Dr. F. R. Schemm and has often proved to be an effective diuretic agent.[1,2] Unfortunately, several complications may accompany this type of therapy. These include dilutional hyponatremia; gastrointestinal symptoms such as bloating, nausea and vomiting; and failure to produce a diuresis.

Alcohol has been utilized for its diuretic effect by substituting a portion of the day's total liquid intake with beer and this procedure has been found to be effective in some patients.[3] Since the diuretic effect of alcohol is achieved through the inhibition of the antidiuretic hormone, it is apparent that therapy with this agent will be most effective in those cases in which the secretion of this hormone is most markedly increased. Diuretic therapy with alcohol should be limited to patients on maintenance management and should not be attempted as the sole form of therapy in seriously ill patients. Recently, alcohol given intravenously as a 3% solution in glucose has been recommended in the treatment of patients with hyponatremia associated with heart failure.[4] Unfortunately, the results of such therapy have been variable and many patients have failed to respond adequately.[5]

Osmotic Agents

The osmotic diuretics include sucrose, sorbitol, mannitol, hypertonic glucose and urea. These agents achieve their diuretic effect by increasing the osmolarity of the tubular urine and thereby limiting the quantity of water reabsorbed by the proximal and distal renal tubules. Each of these agents is capable of producing a profound diuretic effect; however, side-effects such as sclerosing of blood vessel walls and damage to the renal tubular epithelium, tend to limit their usefulness in the management of patients with edematous states. Of this class of substances, one that is often overlooked is urea. In selected cases, urea can be a simple, effective and safe diuretic agent.[6,7] Urea should be administered only to those patients whose blood urea nitrogen concentration is normal or only slightly elevated and in whom renal function is adequate. In such selected patients, 40 to 50 gm. of urea daily in divided doses can produce a very marked diuresis. Although the taste of the urea can be modified by serving it in various fruit juices, it is often repulsive to the patient and adequate dosage levels can not be achieved orally. Urea can also be administered by the intravenous route, and in this manner, the problem of patient acceptance can be obviated. Intravenously, urea can be given as a 4% solution in doses of 1,500 to 3,000 ml. daily.

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Acidifying Salts

The acidifying salts, which include ammonium chloride, calcium chloride, potassium chloride and ammonium nitrate, are only mild diuretic agents of themselves, but they can serve an important role in potentiating the effects of other diuretic agents.[8] Of these, ammonium chloride is most commonly used and can be administered to the patient parenterally in uncoated tablets or in enteric coated tablets. The enteric coated tablets tend to produce less gastrointestinal irritation than do the plain tablets. However, absorption is often unpredictable and the patient may pass the intact tablets in the stool. In contrast, the noncoated tablets are more uniformly absorbed, but some patients complain of gastrointestinal distress after ingesting them. The intravenous administration of ammonium chloride should be limited to those patients who are unable to take this drug orally. The dosage of ammonium chloride must be adjusted to the needs of the individual patient and varies from 4 to 10 gm. daily. A sufficient quantity of ammonium chloride should be given to maintain the serum chloride concentration at a value of 100 to 115 mEq. per liter. Although ammonium chloride has a mild diuretic effect in its own right, it is more commonly administered in order to potentiate the diuretic effects of the mercurial diuretics. In patients with intrinsic liver disease or in those whose liver function is severely compromised as a result of congestive failure, the use of ammonium chloride is contraindicated because of the danger of ammonia intoxication and possible hepatic coma. Similarly, ammonium chloride should be avoided, or used with great caution, in patients with renal insufficiency because of the danger of chloride acidosis.

Xanthines

The xanthines and their derivatives have been popular diuretic agents for many years. They can produce several desirable pharmacodynamic effects including: increased cardiac output, increased glomerular filtration rate and decreased tubular reabsorption of sodium.[9] Classically, the xanthine diuretics include theobromine, caffeine and theophylline. Theophylline is usually administered as aminophylline which consists of theophylline combined with ethylenediamine. The xanthines vary in their potency as diuretics; theophylline being most potent, caffeine least potent, and theobromine occupying an intermediary position.

Most xanthine preparations are poorly tolerated when given orally in therapeutically effective doses, and as a result, the intravenous or rectal routes are usually preferable. Generally, the xanthines when administered alone are therapeutically effective only in patients with minimal amounts of edema. However, aminophylline may be combined with other diuretic substances, such as the mercurials for purposes of its potentiating effects. The usual dose of aminophylline is 0.25 to 0.5 gm. given two to four times daily by the intravenous or rectal routes. Some patients complain of rectal irritation when the drug is given by this route; however, this is often a matter of improper technique in the manner of insertion and can usually be corrected by proper patient education.

Recently, two compounds known as aminometramide (Mictine) and aminoisometradine (Rolicton) have been introduced as diuretics. These compounds represent intermediary steps in the synthesis of the xanthines.[10] They have been shown to be well tolerated and of low toxicity; however, they are only moderately effective as diuretic agents and as such, are useful in only a minimal number of patients with edema. The usual dose of aminometramide is 200 mg. given 1 to 4 times daily, and of aminoisometradine 400 mg. given 1 to 10 times daily.

Cation Exchange Resins

The cation exchange resins gained popularity in the management of edematous states several years ago.[11,12] These substances act by limiting the absorption of sodium from the gastrointestinal tract, and as a result of this they produce a diuretic response. Poor patient acceptance, gastrointestinal disturbances and problems of electrolyte imbalance served to limit the usefullness of these compounds; as a result, they are not generally utilized at present.

Carbonic Anhydrase Inhibitors

The enzyme carbonic anhydrase which is present in the cells of the renal tubular epithelium plays an important role in controlling the acidity of the urine and conversely its sodium concentration. Following the demonstration of the diuretic properties of

sulfanilamide,[13] together with the fact that it served to inhibit the action of carbonic anhydrase,[14] an entire series of related compounds was synthesized and studied. One of the first of such compounds to reach clinical application was acetazolamide (Diamox). Early reports on the clinical use of acetazolamide were encouraging;[15] however, reports of toxic side-effects soon followed and many observers noted disappointing results in attempting to mobilize edema fluid in many instances.[16-19] Consequently, acetazolamide is currently used only in patients with minimal evidences of edema and occasionally to potentiate the effects of mercurial diuretics. The usual dose of acetazolamide is 250 mg. given one to three times daily. Various dosage schedules have been recommended, but none of these has proved to be uniformly effective. The carbonic anhydrase inhibitors are contraindicated or should be used with extreme caution in patients with renal insufficiency or in persons with diminished liver function.

Benzothiadiazines

Following the clinical introduction of acetazolamide, studies of the diuretic properties of many other derivatives of the sulfonamides were carried out. As a result of such studies, a series of chemical compounds known as the benzothiadiazines were produced. The first of these, chlorothiazide (Diuril), was found to be a relatively weak inhibitor of carbonic anhydrase; but it possessed potent diuretic, saluretic and chloruretic properties which were comparable to those produced by the mercurial diuretics.[20] Serious side-effects associated with chlorothiazide therapy are uncommon, despite the fact that most patients tend to develop a moderate degree of hypokalemic alkalosis, an increase in blood uric acid, and an increase in blood urea nitrogen concentrations.[21-24] A number of benzothiadiazine derivatives are currently available for clinical use. These differ from the parent compound only in minor changes in the basic structural formula. All of them are potent diuretic agents, and when administered in adequate doses, they produce comparable effects. Table 1 lists the various benzothiadiazine derivatives currently available for clinical use together with their trade names and the average daily dosage.

TABLE 1—*Benzothiadiazine Derivatives, Their Trade Names and Average Daily Dosage*

Compound	Trade Name	Average Daily Dosage—Mg.
Chlorothiazide	Diuril	1,000
Hydrochlorothiazide	Hydrodiuril Esidrix Oretic	100
Flumethiazide		1,000
Hydroflumethiazide	Saluron	100
Benzydroflumethiazide	Naturetin	10
Trichlormethiazide	Naqua	8
Methyclothiazide	Enduron	5
Chlorphthalidolone	Hygroton	100

Hypokalemia of varying degrees of severity occurs with all of these agents and reflects the combined influences of the kaliuresis induced by the diuretic agent and the hypokalemic effect associated with the accompanying alkalosis.[25] The lowered serum potassium concentration may manifest itself clinically in the form of muscular cramps or muscular weakness and occasionally in the form of increased sensitivity to digitalis. As a result, the physician should be constantly alert for evidences of lowered serum potassium concentration. Serious degrees of hypokalemia can usually be avoided by providing additional potassium in the diet or by prescribing supplementary potassium salts. The hypokalemia can also be modified by supplying small rations of ammonium chloride in combination with the benzothiadiazine derivatives. The action of the ammonium chloride under these circumstances is to modify the degree of alkalosis which is induced by the benzothiadiazine derivative and to prevent the shift of potassium from the extracellular to the intracellular phase. A few observers have reported the development of hepatic coma during benzothiadiazine therapy in patients with advanced liver disease.[26] As a result, caution should be exercised when these compounds are prescribed in patients with decreased hepatic function.

More recently other benzothiadiazine derivatives have become available. These include methyclothiazide (Enduron)[27] and trichlormethiazide (Naqua).[28] The action of these compounds differs from that of the earlier benzothiadiazine derivatives in that their duration of action is more prolonged and they apparently produce less kaliuresis. As a result, diuretic therapy can be achieved with these compounds with less likelihood of

electrolyte imbalance and with therapy administered on an intermittent schedule.

Phthalimidines

While various derivatives of the benzothiadiazine series were being synthesized and put to clinical trial, other possible sulfonamide derivatives were being investigated as possible diuretic agents. One of these, a phthalimidine derivative, chlorphthalidolone (Hygroton) was found to be a long-acting potent diuretic agent which had minimal effects on potassium metabolism in animal experiments. Early clinical studies supported these observations and this compound, chlorphthalidolone, is currently available for clinical use. [29,30] To date, no serious toxic side-effects have been reported. The recommended dosage varies from 50 to 200 mg. daily administered as a single dose. Maintenance therapy may require a dose only every second or third day. As with all diuretic therapy, electrolyte balance should be evaluated periodically and appropriate therapeutic adjustments initiated as needed.

Aldosterone Antagonists

Following the isolation of aldosterone and the identification of its role in electrolyte metabolism, a search was initiated to discover agents which would block or antagonize the action of this hormone. Progesterone[31] was found to have anti-aldosterone properties under certain circumstances; and with further research in steroid chemistry, a series of compounds which served to block the effects of aldosterone on the renal tubule were developed. Of these agents, which are known as spironolactones, Aldactone has been most thoroughly studied and been most widely used clinically.[32] Although this agent may serve as a diuretic in many patients with edema, its principal role is in the management of patients who have become refractory to all other diuretic measures. As a result, spironolactone is usually administered in conjunction with the organic mercurials or with the benzothiadiazine derivatives. The usual dose of spironolactone is 100 mg. given four times daily; however, this should be adjusted to the needs of the individual patient. To date, no serious side-effects or significant aberrations of electrolyte metabolism have been reported in association with spironolactone therapy.

Organic Mercurials

Despite the development of many new diuretic agents during the past several years, the organic mercurials continue to occupy an important position in the therapeutic armamentarium of the physician. Some observers have presented evidence to show that the organic mercurials continue to be the most potent and most predictable diuretic agents available today.[33] Potent preparations suitable for administration orally, rectally, subcutaneously, intramuscularly or intravenously are available. Toxicity is very low and there is no evidence of cumulative effects on long-term therapy.

The most common problem associated with the use of mercurials is the development of the so-called refractory state. Under these circumstances, the patient fails to respond to repeated doses of a mercurial diuretic. Although many factors may play a role in causing a patient to become refractory to mercurials, the most common of these is the development of hypochloremic alkalosis. This results because of the fact that the mercurial diuretics cause a predominant loss of Cl^- and H^+ ions in the urine. Generally, when the serum chloride concentration falls below 90 mEq. per liter, the response to the mercurial diuretics is greatly diminished, or is lost entirely. In such instances, mercurial responsiveness is promptly restored by correcting the hypochloremic alkalosis by the administration of suitable doses of ammonium chloride. Another cause of a loss of responsiveness to mercurials is a marked diminution of renal blood flow and of glomerular filtration rate. This can occasionally be corrected by the administration of intravenous aminophylline in doses of 0.5 gm. in combination with the mercurial diuretic and then repeating the dose of aminophylline alone several hours later.

In some patients undergoing long-term therapy with one of the benzothiadiazines, edema may reaccumulate; and under these circumstances, the periodic administration of a mercurial diuretic by the parenteral route may prove to be effective. Similarly, the organic mercurials may be used in association with spironolactone in order to achieve a diuretic response in a particularly refractory patient.

Summary

A wide variety of diuretic agents are available to the physician today. They produce their effects through several pharmacologic mechanisms and when used alone or in combinations will effect a diuretic response in almost every form of edema. Side-effects of diuretic therapy in general reflect extensions of their basic pharmacologic actions and as a result are usually of little consequence. In a very small percentage of patients unusual or untoward reactions may occur with any of these agents and the physician should be alert to such possibilities. The newer diuretic agents exert potent effects on electrolyte and water metabolism and these effects may be potentiated if the body's normal compensatory mechanisms are compromised (i.e., in severe liver or renal disease). As a result, caution should be exercised when these agents are administered under these circumstances. It is anticipated that further developments in the area of diuretic agents will provide an even greater variety of such substances in the future.

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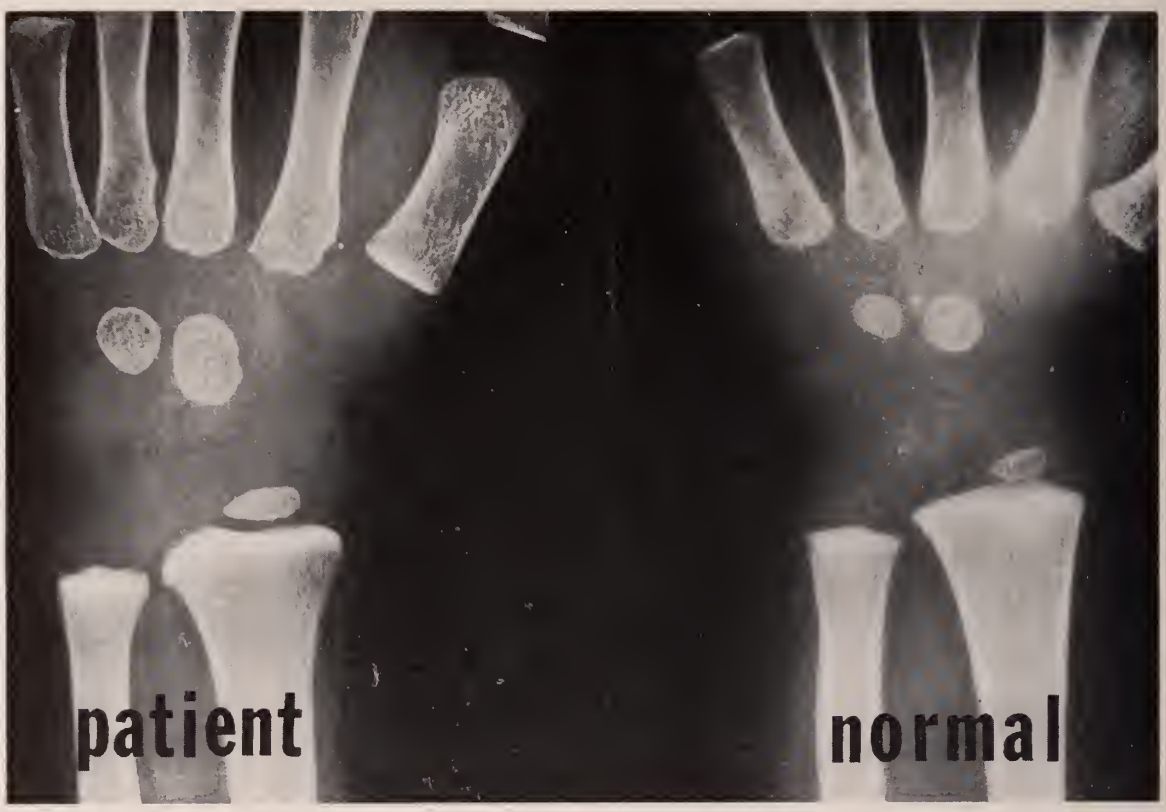

one of a series

ROENTGEN RIDDLE . . .

HISTORY: A 20-month-old female entered with convulsions. Four days preceding, lethargy and vomiting were noted, and the child developed a limp.

PHYSICAL EXAMINATION: The child appeared pale, lethargic, and mildly dehydrated. A slight limp, ataxia, strabismus, and a palpable liver were found.

LABORATORY FINDINGS: Hemoglobin 6.0 gm.

X-RAY: Osteosclerosis was evident in the discoid area on the metaphyseal side of the epiphyseal plate in the radius and ulna. Skull films revealed diastasis of the sutures compatible with increased intracranial pressure.

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SEE DISCUSSION ON PAGE 255

Epiploic Appendagitis Simulating Acute Appendicitis

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PATHOLOGIC changes in the epiploic appendages may mimic many acute abdominal inflammatory syndromes. Infarction of an epiploic tag with superimposed epiploic appendagitis is usually confused clinically with acute vermiform appendicitis. A preoperative distinction can only be tentative. Should laparotomy fail to disclose the usual sources of acute abdominal pain, epiploic appendagitis warrants consideration.

Case Report

A 31-year-old married female was examined on April 30, 1960, because of right lower quadrant abdominal pain. The pain had been present for one day and had become progressively more severe. It had been localized to the right side of the lower abdomen since onset. There was associated anorexia and nausea but no vomiting, diarrhea, or symptoms referrable to urination. The pain was primarily aggravated by ambulation or pressure on the right side of the abdominal wall. She remarked, "I believe that I have appendicitis." There had been no episodes of similar abdominal pain in the past.

Ten years previously her first pregnancy was terminated by Cesarean section because of borderline pelvic measurements and the frank breech presentation of a large fetus. One year later, during the eighth month of gestation, rupture of the uterus accompanied by placental detachment, intraperitoneal hemorrhage, and fetal death necessitated an emergency supracervical hysterectomy. The remainder of her past history was that of health.

The temperature was 98.4 F. On inspection, the abdomen was moderately obese and exhibited the scars of previous gynecologic surgery. Pressure tenderness was elicited over the mid-right lower quadrant with questionable rebound tenderness at that site. Pelvic and rectal examination added no additional information. There was no evidence of a mass.

A leukocyte count was 13,450 with 80% neutrophils and 20% lymphocytes. The hemoglobin and urinalysis tests were normal.

Laparotomy was preformed three hours after examination with a preoperative diagnosis of vermiform appendicitis. Approximately 3 cm. above the appendix on the anterior cecum a hemorrhagic firm 2x1x0.5 cm. tab of tissue was excised. The base was very narrow and suggested an element of torsion. Microscopically this proved to be a hemorrhagic appendix epiploica. The vermiform appendix was removed in a routine fashion and did not show gross or microscopic evidence of inflammation.

The patient had an uneventful postoperative period and has had no recurrence of abdominal pain.

Comment

The term "appendagitis" is used in this article to refer to inflammation of an epiploic appendage regardless of its location on the large intestine; use of "epiploic appendicitis" has been avoided because of the specific application of "appendicitis" to the vermiform appendix.

The epiploic appendages are fat-filled, serosa-covered appendages occurring on the large intestine, including the appendix but excepting the rectum. The enveloped fat is a continuation of the subserosal fat of the intestinal wall. Approximately 100 in number, they are related intimately to the longitudinal bands of the colon, usually appearing in two rows. Blood is supplied by small branches of the circular artery that vascularizes the adjacent segment of colon.

Primary inflammation in an epiploic appendage, with the production of abdominal pain that prompts surgical intervention, has provided the major source of interest in these appendages. The available literature discloses less than 125 reported cases. There

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is no doubt that this entity is more frequent than the literature would suggest. The incidence of epiploic appendagitis, as compared to that of acute vermiform appendicitis, approximates 0.2% according to Bearse[1] and Marinis and Cheek.[2]

The sex incidence is approximately equal with the majority of the patients being between 20 and 50 years of age. Obesity is almost always present and it is felt that the appendages which are larger in the obese person, are more prone to torsion or infarction.

Pain, when present, is due to irritation of the adjacent parietal peritoneum. The duration of pain parallels that of vermiform appendicitis and is usually moderate to severe. Nausea occurs in approximately one-half and associated vomiting in one-third of the patients. Bowel elimination is usually unaffected. The temperature is commonly elevated one to two degrees Fahrenheit and the average leukocyte count approximates 12,000 cells per cubic millimeter of blood.[3]

Vermiform appendicitis has been the prevalent preoperative diagnosis, being made in two-thirds of the reported cases. Fifty per cent of the inflamed appendages have occurred on the sigmoid colon with approximately one-half of that number being found on the cecum. The mobility of the sigmoid colon can allow an inflamed appendage located thereon to produce symptoms in the right lower quadrant. Torsion of the diseased appendage is commonly felt to be the usual precipitating event. However, it has only been visualized in approximately one-half of the reported cases. The chain of events producing torsion is not known.

A definite preoperative distinction between epiploic appendagitis and the acute vermiform appendicitis must be tentative. However, several differences are worthy of consideration. Epiploic appendagitis is commonly a disease of middle age and the patients are usually overweight. The pain, at the onset, is almost always localized at the site of the pathology. Anorexia, nausea, vomiting, and constipation are more likely to occur with vermiform appendicitis. In general, the patients with acute vermiform appendicitis are usually sicker with a more marked febrile and leukocytic response.

An abdominal mass was palpable in approximately one-third of the cases previously reported.[3] Although the appendage may be large enough to be felt, the mass is usually due to the inflamed appendage being walled off by adjacent epiploic tags or omentum.

The treatment of a diseased epiploic appendage is ligation and excision. It must be kept in mind that a diverticulum may be enclosed within an epiploic appendage. In the acute phase, the diseased epiploic appendage uniformly reveals thrombosis of the nutrient vessels, with secondary infarction and inflammation. Subsequent detachment may occur, and detached epiploic appendages are the most frequent cause of intraperitoneal loose bodies.[4]

Summary

Infarction of an epiploic tag with superimposed epiploic appendagitis usually has been confused with acute vermiform appendicitis. A preoperative distinction can only be tentative. Should laparotomy fail to disclose the usual source of acute abdominal pain, epiploic appendagitis warrants consideration. The treatment is surgical excision of the diseased appendage. An instance of epiploic appendagitis simulating vermiform appendicitis is presented.

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Griseofulvin in Fungous Infections
A Review of 50 Cases

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A NEW ORALLY administered antibiotic, griseofulvin, has been found to be effective in the treatment of certain superficial fungous infections of the skin, hair and nails. The antibiotic was initially isolated from *Penicillium griseofulvum* dierckx by Oxford[1] and his associates in 1939. Now it is also being isolated from *P. patulum, P. janczewskii, P. raistrickii.* The drug was first used clinically in patients in the fall of 1958 by Riehl[2] in Vienna, Williams and associates[3] in London, and by Blank and associates[4] in Miami, Florida.

Griseofulvin is a white, bitter, neutral, thermostable compound. It is poorly soluble in water but slightly soluble in methanol and ethanol. The drug is carried by the blood stream and becomes a part of each new epidermal cell produced during that interval. It is incorporated into the keratin so as to make it resistant to the fungi until it is finally shed. It is effective against various species of *Trichophyton* such as *Trichophyton rubrum, T. tonsurans, T. schoenleini, T. mentagrophytes* and *T. Verrucosum.* Microsporum audouini and *M. canis* and the *Epidermophyton floccosum* also are sensitive to griseofulvin.

It is therapeutically ineffective in the treatment of moniliasis, actinomycosis, blastomycosis, sporotrichosis and tinea versicolor. The drug is fungistatic and not fungicidal. It produces a curling and shriveling of the advancing hyphal thread of the invading fungi.

Blood studies, urinalysis, liver function tests, kidney function tests and studies of the peripheral blood and the bone marrow, together with clinical observations performed by many investigators in the field, before, during and after treatment with griseofulvin, reveal that it is a drug of very little toxicity and few side-reactions. Side-reactions are less frequent in children than in adults and there is no evidence of penicillin cross sensitivity. A few cases of nausea, abdominal discomfort, diarrhea and headache have been reported and also some cases of urticaria. At times there is a leukopenia that is temporary in that after discontinuing the drug for two weeks, the white blood cell count comes back to normal and the drug can be resumed without subsequent leukopenia.

The effective therapeutic dose for children up to 12 years of age is 10 mg. per pound of body weight as a total daily dosage, or 22 mg. per kilogram per day. In older children and adults the average effective daily dosage is 1 gm., in four divided doses during the day of 250 mg. each.

Clinical Results

The present study of 50 cases of superficial fungous infections consists of 25 children and 25 adults with sex differentiation being 30 males and 20 females. Fifteen cases of tinea capitis were treated with griseofulvin. These children had the gray scaly patch type caused by the *M. audouini* type of fungus. The clinical diagnosis was confirmed by a turquoise or greenish blue fluorescence of the short stubby infected hairs as seen with the Wood's lamp. Potassium hydroxide (KOH) preparations and cultures on Sabouraud's media were also used as laboratory aids in confirming the diagnosis. The children were treated with the multiple dose, using 10 mg. per pound of body weight and giving the total daily dosage in four divided doses during the day. As seen in Table 1, all of the children got excellent results from this new antibiotic. In Table 1 excellent response to treatment is based on cases where the disease completely cleared on griseofulvin; fair response, in which there was definite improvement but the condition did not clear, and poor response included those cases that did not improve whatsoever.

TABLE 1—*Griseofulvin Therapy—Review of 50 Cases*

Location	Cases	Response						Average Length of Therapy
		Excellent		Fair		Poor		
		No.	%	No.	%	No.	%	Weeks
Scalp	15	15	100	-----	----	-----	----	4
Groins	5	4	80	1	20	-----	----	4
Hands and Feet	4	2	50	1	25	1	25	5
Body	4	2	50	2	50	-----	----	3
Feet	7	3	43	3	43	1	14	4
Hands	5	2	40	3	60	-----	----	5
Nails	10	3	30	2	20	5	50	16

Five cases of tinea cruris were treated and in four of the individuals the disease completely cleared in approximately four weeks and in one individual it improved but did not completely clear.

In Table 1 the results of treatment of tinea infections of the hands and feet and body show about 50% excellent results. Cases of tinea involving only the feet or only the hands and tinea of the nails showed poor response to treatment. The average length of treatment was from three to five weeks, except in cases of the nails where it was an average of 16 weeks. One can expect therapy to be of longer term in cases of nail involvement because it takes approximately four months for the fingernails to grow out and six months for the toenails to completely regrow.

Figure 1 shows the effectiveness of griseofulvin in the treatment of the 15 cases of tinea capitis treated in 1959 and 1960 as compared to the lengthy form of treatment of 15 cases picked at random from a group of cases that I treated in 1948 using local salves,

Fig. 1—Duration of griseofulvin therapy for tinea capitis as compared to other treatment.

shampoo and weekly manual epilation. In the treatment with griseofulvin the disease cleared in four cases in three weeks, five in four weeks, two in five weeks, two in six weeks, one in eight weeks and one in twelve weeks. Of the 15 cases reviewed that were treated at Milwaukee Children's Hospital Outpatient Department in 1948, the disease in one case cleared in three months which was the shortest period of time for complete healing with local manual epilation and local treatment.

The longest period of time for treatment with griseofulvin was only three months. Treatment in 1948, as shown in Figure 1, took 4 months to 12 months, respectively. One case took 20 months and another 22 months. These latter two cases were a brother and sister who did not report to the clinic at regular intervals. On two separate occasions two and then three months elapsed before they came in. It was difficult to get any cooperation from the parents at home. All during this time these children were infectious and the condition was transmissible.

We could say that tinea capitis is the crowning glory of griseofulvin therapy because the most brilliant results have been obtained with it whether it is caused by *M. canis* or *M. audouini* or *T. tonsurans*. It is least effective in the treatment of the nails and is effective in the treatment of the infections on the trunk and groin.

In addition to the aforementioned 15 cases of tinea capitis treated, we have treated three children with this condition using the single massive dose of 4 gm. of griseofulvin as suggested by Robinson and his associates in Baltimore. All three of our cases did not respond to the massive dose and they are now on the multiple dosage schedule.

In our series of cases only one patient developed abdominal discomfort and headache and the drug was discontinued; when it was resumed again, the patient developed similar symptoms. One case of urticaria developed while the patient was on this drug; and we had one patient, a child of eight years, who developed a leukopenia while on this medication. Two weeks after the medication was stopped, her blood count was back to normal.

Summary

Fifty cases with proven superficial fungous infection have been treated with the orally

administered antibiotic griseofulvin. These cases represent dermatomycosis of the hair, skin and nails. Dosage of 1 gm. a day for an adult administered in four divided doses during the day and smaller doses for children are therapeutically effective. The average length of time for clearing of the scalp and skin is from four to five weeks and of the cases of onychomycosis or fungous infection of the nails, approximately four to six months was necessary for complete recovery. It is most effective in the treatment of tinea capitis and next in its effectiveness in the treatment of tinea of the groins and tinea of the glabrous skin, hands and feet. It is desirable to study these cases with potassium hydroxide preparation, cultures and the use of the Wood's lamp in an effort to differentiate these infections from other simulating skin diseases, as the proper diagnosis is essential.

Griseofulvin is proving to fulfill the long-time need for a systemically administered drug to combat superficial fungous infections of the skin and its appendages.

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ROENTGEN RIDDLE continued from page 250

DISCUSSION: Heavy metal intoxication, most probably lead, was the likely diagnosis. Interestingly enough, the laboratory afforded the clue by noting stippling of the red cells. Further questioning revealed the child nibbled on plaster since she was able to walk.

Generally, lead absorption in infants is through the gastrointestinal tract. Common sources available to children are paints, either white lead or chrome yellow, and green. The latter two are found on inside walls of older homes. If battery casings are used as fuel, absorption is through the respiratory tract.

Following the absorption, the heavy metal is deposited in the soft tissues and bones. Brain lesions are edema, hemorrhages and focal necrosis. In bones, the lead is an insoluble tertiary lead phosphate. This is not detectable radiologically in adults but in children causes sclerosis at the distal end of the metaphysis of long bones and at the costochondral junctions in the chest roentgenogram.

Confirmation of lead absorption can be obtained by serum values. Values of 0.06 mg. per 100 ml. or more indicates at least increased exposure. Urine lead determinations however, are more available. According to some, values in excess of 0.08 mg. per 100 ml. in a 24-hour specimen always indicates intoxication if the patient is between 6 months and 14 years. An increased protein content and positive Pandy's test indicative of abnormal globulin are the abnormal spinal fluid findings.

Of more immediate help to the practicing physician is an office laboratory procedure. This detects the presence of urinary porphyrins seen in cases of heavy metal intoxication. Five cc. of urine, acidified with 2 to 3 drops of glacial acetic acid to which is added 5 cc. of ether is shaken vigorously. After the layers separate well, a salmon-pink fluorescence in the ether layer when viewed under a Wood's lamp indicates the presence of porphyrin.

TREATMENT: Chelating agents seem to fulfill the promise of rapid de-leading without precipitation of symptoms. Edathamil calcium disodium (calcium-disodium versenate) is one of these agents and exchanges calcium for lead without apparent toxicity. An acceptable dosage schedule is 0.6 gm. per 15 kilograms (30 lbs.) of body weight twice a day for 3 days added to an intravenous solution of 5% glucose and water.

Venereal Diseases Again Cause for Concern

By A. L. VAN DUSER, M.D.

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SOMETIMES a little success can be a dangerous thing. The control of venereal diseases is a good illustration of this point. For centuries these diseases have been among the world's major public health problems, contributing heavily to infant and adult mortality rates and to the neurological, cardiovascular, and blind morbidity loads of society. Today, after a period of complacency, we are once again seeing increases in the number of infectious venereal disease cases.

Modern breakthroughs against syphilis began in 1906 with the discovery of the Wassermann test which provided physicians with a practical means for finding syphilis, particularly in asymptomatic patients. Shortly thereafter Ehrlich provided a greatly needed therapeutic agent, arsphenamine (Salvarsan). Major progress was made in 1937 with the inauguration of a nationwide control program which effectively brought medical and social knowledge more fully to bear against these diseases. This program brought about a marked acceleration of declining mortality and serious advanced disease rates. It also produced an initial increase in reported morbidity rates, but this was a favorable index resulting from better case finding and reporting endeavors by physicians and public health workers.

The introduction of penicillin therapy for syphilis in 1943 was a significant advancement. Its therapeutic effectiveness needs no comment. Its cheapness, ease of administration, and rapid treponemacidal action have made nearly every doctor's office a veneral disease treatment center and allowed the closure of many public clinics. But penicillin also had a serious adverse effect on venereal disease control by creating a following of persons who mistakenly assumed that this miracle drug by itself constituted an adequate control program. By 1950, and over the objections of those best informed, such thinking brought forth a deemphasis of the importance of venereal disease control and curtailment or abolishment of many essential activities. The main foci of infection which propagate venereal diseases in society are not the diagnosed cases, but rather the undiagnosed cases among sources and contacts. In reality, good venereal disease control is essentially good case investigation or case finding.

In reviewing the status of venereal diseases, it is evident that diagnostic and therapeutic advances and the application of public health programs have had pronounced effects. The over-all mortality rate from syphilis has had a tenfold decrease since 1900, with deaths from paresis falling from a rate of 7.4 to 0.2. The infant mortality rate from syphilis has fallen from 124.7 in 1915 to an estimated 0.5. In 1900, 30% of the admissions to schools for the blind were caused by gonorrhea; now they constitute less than 1%.

However, in spite of adequate knowledge and diagnostic and therapeutic means with which to complete the job of eradication, the fight against venereal diseases remains far from won. There exists an estimated prevalence of 1,200,000 cases of syphilis and an incidence of 1,000,000 gonorrhea cases in the United States. More ominous are the numerous reports from all areas of the country, and from other parts of the world, which show an increase in infectious venereal diseases, particularly in teenagers. A decreasing primary and secondary stage syphilis trend bottomed out in 1955 (Fig. 1) and the trend is now upward. Fiscal 1960 showed a 53% increase over fiscal 1959, which in turn was 23% higher than the preceding year. Although new cases remain grossly under reported, gonorrhea still ranks third and syphilis fourth among significant communicable diseases being reported to the Federal government (Fig. 2).

It is time to remind ourselves that if venereal disease gains are to be held, or advanced, in Wisconsin, that investigations of sources and contacts to diagnosed infectious cases must be intensified. There are no isolated cases of infectious syphilis or gonorrhea; every case is related to at least one and usually to numerous other ones. The known

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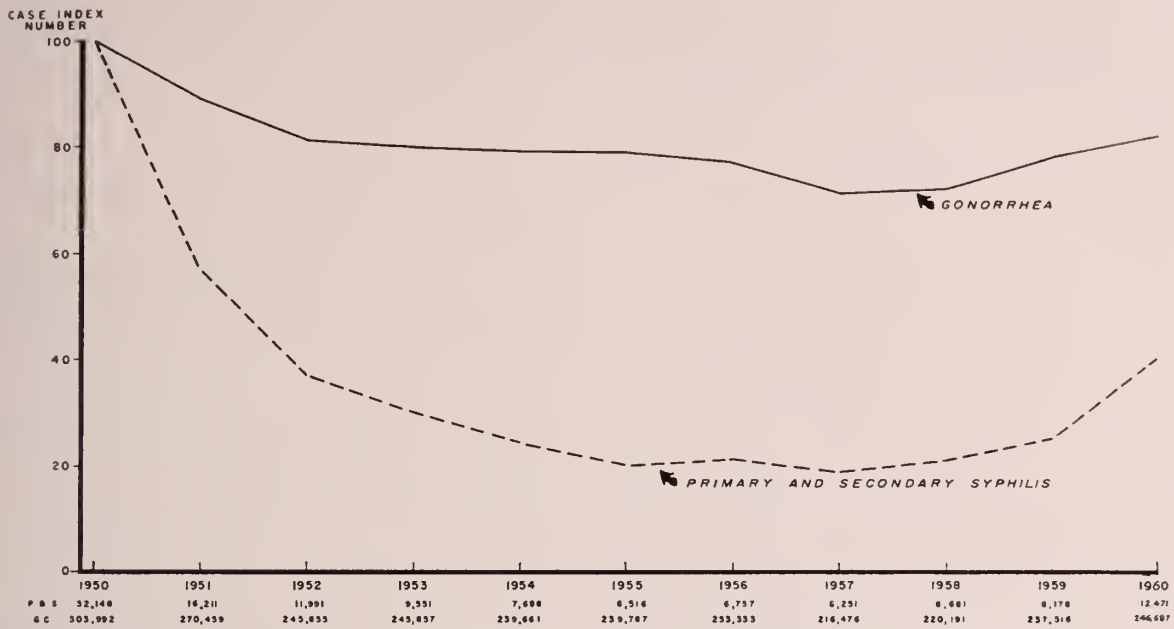

Fig. 1—Cases of primary and secondary syphilis and gonorrhea, United States 1950–1960. (From *1960 V.D. Chart Series*, U. S. Department of Health, Education and Welfare, Public Health Service.)

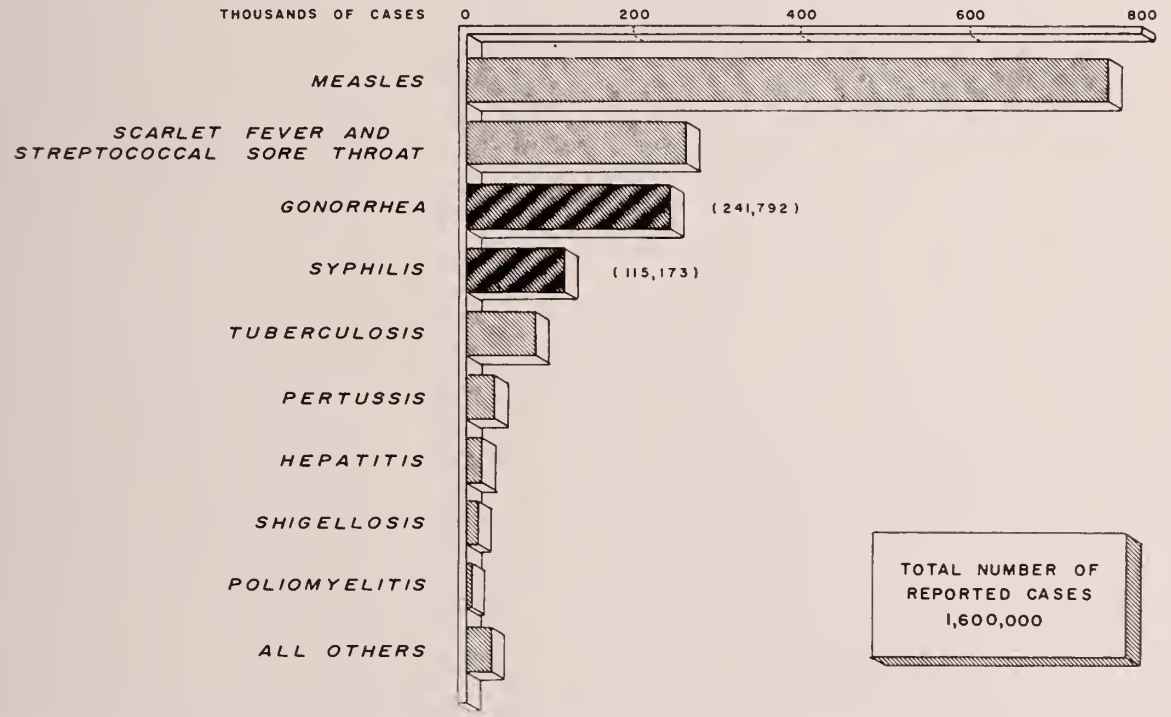

Fig. 2—Number of reported cases of communicable disease, United States, 1958. (From *1960 V.D. Chart Series*, U. S. Department of Health, Education and Welfare, Public Health Service.)

infectious case is the door through which unknown cases can have their disease brought to medical diagnosis and treatment, and through which the spread of disease can be halted. Physicians have moral and legal obligations to bring venereal disease sources and contacts to diagnosis, or to request such assistance from the State Board of Health. The department invites such requests, and in turn recognizes similar obligations toward patients and physicians in joint efforts to eradicate venereal disease.

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COMMENTS ON TREATMENT

On Statistical Importance

By HARRY BECKMAN, M.D.
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I HAVE always felt that it is unnecessary for anyone to master statistical methods unless he is a professional statistician. What is needed by the busy practitioner of medicine, who would like to follow the literature with critical acumen, is not a knowledge of laborious mathematical procedures but rather a quick method of determining whether the recorded findings in a small number of cases have significance. "Quickie" methods are never presented in statistical courses, but they are in existence and can be quite useful.

My own rule of thumb for forming a reasonably reliable judgment of the significance of such findings is one that Alan Gregg, late director of the Rockefeller Foundation, used for many years; it was brought to his attention by the mathematician, R. A. Fisher. Here it is:

Let "a" = the number of positive reactors

Let "b" = the number of negative reactors

Then, if $\frac{(a - b)^2}{a + b} = 4.0$ or more, you can be reasonably sure that the finding begins to be within the significant range.

Examples:

In a study in which there were 76 patients, all treated alike with a certain drug, 45 gave the response that was hoped for and 31 did not; then

$\frac{(45 - 31)^2}{(45 + 31)} = 2.5$, and the findings are not indicative of more than chance occurrence.

But if 48 had given the positive response and 28 had not; then

$\frac{(48 - 28)^2}{(48 + 28)} = 5.2$, and significance may be well considered.

Another situation in which one often needs some basis for forming a quick and serviceable judgment is that in which significance is claimed for a certain mean figure representing status in a treated group as compared with the mean figure, together with its standard deviation, of the untreated controls. The thing to do here is to project the standard deviation of the mean of the control twice in either direction; and if the new figure is not greater than this projected figure, either above or below, then the alteration produced by the use of the drug is not greater than might have been produced by chance. For example, suppose the mean titer of a drug recoverable from the plasma of an adequate number of individuals is 18.6 ± 3.2 mg./per cent, and the titer in the plasma of a group treated with a potentiator in the hope of raising this figure is 30.0; then, 18.6 with its standard deviation extended twice becomes 25.0, and the new figure is significant. But if the standard deviation of the 18.6 figure had been 6.4 instead of 3.2, the extended figure would have been 31.4, and the new figure of 30.0 would have been of very doubtful significance. Or if the mean had been the original 18.6 ± 3.2 but the new figure only 28.0, there would have been much doubt of the latter's significance.

Of course neither of these "rules" will apply to all cases, but they are applicable in most instances and hence very useful.

Special to the Journal

Economic Problems of Industrial Medicine

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THE SUBJECT of the economic problems of industrial medicine can be presented both from the immediate or short-range and the long-range point of view. According to my experience of some 30 years' involvement in occupational medicine, each of these aspects must be considered from the viewpoint of three different groups involved, namely, the employees, management, and physicians. The industrially injured or ill worker is immediately interested in the matter of wages and reimbursement for lost time either from sickness benefit or compensation sources. Industry in turn looks at once to the problem of interference with production if there is time lost by a worker. The physician, finally, is asked either to keep the man at work or to return him to work as soon as medically possible. In turn, he expects some remuneration for his services whether they be on a part-time or a full-time basis. There is a distinct economic problem shared by all, each from his own rather short-range view.

If the individuals concerned, however, take time to consider the matter, they may well think seriously of the longer-range point of view in which they all have a common objective. This objective is not only to return a particular injured or ill employee to work but also to see that this temporary disability does not afflict him again and certainly does not occur to others. The long-range aim, then, should include the application of immediate treatment combined with the ever present goal of preventing the recurrence of the disability or illness. That is modern "good medicine."

Actually this idea of preventive medicine studied out in the workshop is not new. Over 260 years ago, Ramazzini, a gifted and learned Italian physician, besides his lucrative court practice, felt it his duty and privilege to study "the diseases of artificers" or workers. He was not too proud to descend into the pit by the side of workmen so he could himself experience and understand the grievous and pitiful conditions under which the so-called lower classes were then forced to work. As he said, "The plan of this work compelled me to make repeated visits to the workshop in order to explore thoroughly the exciting causes of the diseases to which workers are exposed. Accordingly I have tried to unearth in the shops of craftsmen, for these shops are schools whence one can depart with more precise knowledge, suggestions for medical precautions for the prevention and treatment of such diseases as usually affect the workers." This was written in 1700.

In the case of the modern worker, he sees that if he would protect his job security he must get well as soon as possible so that he may be rehired for his old position. Industry also realizes that it has a tremendous investment in training and stands to gain a good deal if it can send an experienced man back to his old job as soon as possible. The physician, with his double responsibility, first to the patient and then to industry, should perhaps be able to lift his sights still higher than the other two parties to the problem because he should be especially trained to realize his community responsibility. One of his main obligations to society is to keep the population healthy and not just to treat them after accidents or illnesses have occurred.

Physicians who act as advisors or consultants to industry in large or small towns have long been expected first of all to be able to give counsel as to the advisability of hiring workers.

In my memory and in the memory of many men here, such pre-employment examinations were often instituted primarily to pick the cream of the labor crop so that management would suffer no possible expense if a man with some chronic nonoccupational illness might seek a position. Now, however, all over Wisconsin and the country as a whole it is generally admitted that the purpose of the

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pre-employment examination should be for placement of the individual in a position where he is able to do a day's work and thereby support himself and his family. With the old technique of screening or weeding out all those who had even minor abnormalities, this process of selfish exclusion simply tended to pile up a number of men prematurely on the economic scrap heap. Even though these workers were handicapped by certain physical abnormalities, it was found eventually that such so-called less-than-perfect human beings realized more acutely than the entirely healthy, the importance of regular full-time attendance at their work. This is true not only in the polio and amputee cases but also in those who have had some type of heart or other disability associated with cardiovascular disease. In my 30 years as a consultant medical director examining thousands of employees, I have rarely disapproved employment—perhaps a dozen cases. I have seen no untoward result for either the employee or the employer from this liberal view.

In addition to the placement examination of the newly hired and the old employee returning to work after illness, there is another type of examination, the periodic examination. The details of such periodic examinations are beyond the scope of this paper and have been widely published. This specialized study should be thoughtfully considered and carefully put into operation in any industry especially where there is some type of unusual chemical hazard.

It is obvious that the presence of these hazards requires special engineering and medical control techniques. Medical control is a check on engineering control. All of this adds to the economic problem. In modern industry which is becoming more and more basically chemical, there is likely to be a hidden hazard in the majority of manufacturing operations. Toxic dusts, fumes, vapors and gases are quite likely to occur in unexpected places even in small industries and the physician must be on the alert to anticipate illness therefrom. It is his duty to take the initiative in protecting the worker especially in the small industries. He must keep abreast of many new industrial developments by first-hand observation and plant tours into every nook and corner of every industry over which he has any responsibility.

For example twenty years ago I was asked to speak in Michigan on the management of health programs in industry. I felt that the occasion required more than my appearance as a speaker, and I suggested to my host, a surgeon, that he arrange for my seeing two plants where the medical hazard was complicated and where I could learn more of the subject on which I was to speak later. He had me see with him one brass foundry with a problem of lead, and one furniture factory with problems of paints and solvents. Later in introducing me he acknowledged a debt. He said that in the 30 years he had been director of health services for these two plants, on that day, for the first time, he had actually been in the factory to see the places where his patients worked. Now he could begin to grasp the problems that were behind the individual cases he had been seeing all these years at his office, outside of the plant.

Prevention is Necessary

One must not wait until a man becomes desperately short of breath from the inhalation of cadmium fumes to look for an industrial etiology. The end stage of pulmonary edema not infrequently seen in these conditions is difficult to treat and often is fatal. The best treatment therefore is prevention and here management, worker, and physician must work together as a team. When all concerned realize the potential dangers, any material can be worked with safely providing that appropriate techniques have been thought out in advance. Naturally these measures cost money but will save money as well as lives.

To be alert to such potential emergencies in our modern chemical industries is one of the responsibilities of every physician regardless of his immediate expenditure of time and money. Naturally he should expect to recoup such expense. If the physician will first of all familiarize himself with the rules and safe-working threshold concentrations available for fifty cents from the Wisconsin Industrial Commission in their *Rules on Toxic Dusts, Fumes, Vapors and Gases*, he will have made a good start on his self-education. Further evening and midnight hours can be spent to advantage in reference to a number of texts and journals available in every medical school and county medical society library. More detailed information can be obtained promptly by writing the American Medical Association library in Chicago as well as the Crerar Library and that of the Surgeon General.

Some will say that such overtime study is beyond the time available to the average physician whose program is already crowded nearly to the limit. I can understand this because for nearly 30 years I had a practice of internal medicine and coupled this with many hours of burning midnight oil spent on study of various problems of industrial health.

For this overtime effort there is not only the satisfaction that one gains from becoming conversant with cause and effect of occupational disease but also the very practical betterment of one's economic status that such study generates. It is my conviction in this connection that such special application and clinical research is worthy of recompense. It should not be furnished without adequate remuneration. It has been my experience that industry has learned that it must pay and should pay for all services rendered. Therefore, I never review a file or offer any advice, curbstone or otherwise, without expecting an adequate fee in return. A physician who desires to increase his practice simply by offering free consultation on medical problems in industry is doing himself and his fellows no good turn. In the end he will not have the respect of the industry to which he is offering free or cutrate service and will often find his advice is unheeded.

One of the most powerful governing and driving forces involved in our modern civilization is that of enlightened self-interest. The worker, the industry, and the physician all gain financially if they work together to prevent illness and disability in industry. The worker must be trained by patient instruction and by financial penalty if he does not abide by proper safety advice and use of protective equipment. Management in turn has learned that if it does not furnish a safe place in which to work and live and breathe, there will be penalties which will promptly sharpen its interest in appropriate self-education. Industrial hygiene workers, either private full-time specialists or our own Industrial Hygiene Division of the State Board of Health of Wisconsin, have a tremendous amount of technical and engineering information available to protect the worker. If the industrialist and the worker do not avail themselves of these protective devices and skills, they will have to learn by having pressure applied to their pocketbook. The agency in this state which has proved itself most successful in protecting the worker by applying such appropriate economic pressure is the Wisconsin Industrial Commission, a national and international leader in its field.

In the end all of these agencies as well as the worker depend on the skill and understanding of a physician for treatment and ultimate prevention of industrially connected injuries and illnesses. The physician alone must make the medical study and decision as to whether a particular patient is ill or is likely to become ill from his working environment. It is he who must make an estimation finally whether any residual damage has been left for which compensation should be awarded. Furthermore, the physician is extremely well qualified to give preventive counsel to management and worker alike so that workers can continue to work in industry with no disability. From the point of view of management the services of a physician may seem to be a heavy economic problem. The record has shown, however, that no experienced well qualified physician in occupational medicine needs to feel apologetic about the value of his services. Both industry and the worker benefit greatly from the conscientious effort of such a physician.

Other Compensations Than Money

Placing a dollar value on their services is abhorrent to many young physicians. Eventually in an effort to face our own economic problems at home, we often goad ourselves to become as realistic and hard-headed as any businessman. We all know, however, that we of the profession of medicine have other compensations than that of pecuniary reward.

These other compensations derive from the satisfactions involved in the practice of a wide range of scientific techniques in situations which often require the utmost in human understanding.

Through his day-by-day contact with workers, in his office, and out in the plant, the men come to learn that the physician in charge is primarily interested in their welfare and safety as he deals with them frankly, without subterfuge or evasion. It has been my experience that they so trust the plant physician that they come promptly to him with their fears about an unsafe process even before they feel free to discuss them

one of a series

Medical Stamps

POMPILIO MARTINEZ
(1870–1937)

Colombian physician. Professor of pathology and surgery at National University. He performed 35,000 operations. Author of medical books. Fellow of American College of Surgeons. Practiced for a time in Boston. Colombia #598.

ROBERT PICQUE
(1877–1927)

A life long sanitarian. In the French Sanitary Service. Special training in Anatomy and Surgery. Doctor of Sciences and Professor of Anatomy in University of Bordeaux. Member of the Scientific Training Academy Val-de-Grace.

* * *

ACKNOWLEDGMENT: Reproduced by permission of Oscar Gottfried, New York City, author of "Doctors Philatelic," bibliography of nearly 300 illustrative medical stamps, which is available at $3.00 from The New York Physician, 1440 Broadway, New York 18, N. Y.

* * *

Physicians interested in obtaining medical stamp displays for exhibit purposes, write Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin.

with the union steward or their own foreman. If a physician is honest with himself and others, he can become a key man in a health organization composed of the worker, management, and medical department.

In addition to the confidence of the worker regarding his work conditions, the plant physician's human contacts offer him another intangible recompense. Just as in the case of a family physician, the occupational physician may render invaluable aid as he counsels a worker struggling with personal problems involved in facing life and death at home. The rare art of listening, such as the skilled psychiatrist has learned from training and experience, when mastered by a plant physician can result in valuable furtherance of the employee's confidence. So skillful can the physician in industry become in understanding and fostering the working complex of labor, technician, and management that in a few instances such physicians have been chosen as vice-presidents in charge of all personnel problems.

In summary let me say as when I gave a paper on "Compensations to the Physician in Occupational Medicine" in the Symposium on Occupational Medicine for the Private Practitioner before the Joint Meeting of the American Medical Association Section on Preventive Medicine and the American Academy of Occupational Medicine at San Francisco, June 24, 1958: "The physician in occupational medicine is obliged to meet the challenge of the varying demands of industries in which new processes are being introduced every day and the diagnostic horizons are constantly widening. Therapeutic and prophylactic skills must be correspondingly broadened. Frequent visits to the plant and patient attention to employees' complaints result in the gradual accumulation of priceless experience. When the confidence of employees and management has been earned, the physician finds that industry can provide him not only with advantages of economic security but also with the assurance, in many instances, of financial support for a stimulating program of continued medical education and clinical research. Through the study of occupational disease the medical profession can and must contribute to modern industrial society."

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561 North 15th Street (3).

The President's Page

WHAT IS YOUR ANSWER?

TENDERNESS IS not weakness. Kindness is not emotional instability. Affection is not softness. The practical, rugged and testing responsibilities of the family physician can sometimes tempt the practitioner to give secondary consideration to the fundamental emotions which characterize our civilization.

After years of intense study and research involving the science of medicine, it is occasionally possible for the individual physician to become so absorbed with the unique routine that his profession requires and with the vocabulary that it employs that he forgets the words and the phrases and the emotional manifestations which characterize the layman. It is imperative and important that the family physician keep himself well exercised in the art of humanitarianism.

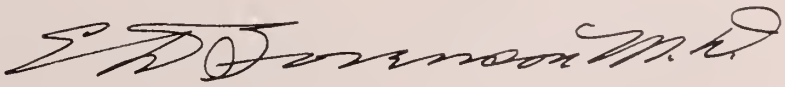
Science in its findings has scarcely touched the therapeutic value of human emotions. We do know, however, for a fact that the morale of the patient and the contributing morale of the family have a value that very frequently constitutes the margin and the difference between life and death.

A subject for surgery commits himself into the hands of his family physician. He considers this physician the best doctor in his world. That is why he chose him. If the anxious relatives who surround the patient and the patient himself can feel and sense the beautiful intangibles of integrity, tenderness, kindness and affection, a situation is created which serves as a magnificent supplement or complement to the hand of the surgeon. No physician ever becomes perfect enough in the fulfillment of science not to need the therapeutic values which grow out of tenderness, affection and genuine concern. These emotions must never be substituted for scientific realities in the material realm; but even so, scientific realities involving matter must never be substituted for the great emotional intangibles which lubricate and stabilize this thing which we call civilization.

Gentlemen of the medical profession, we are being threatened on all sides by a philosophy that is and should be a total stranger to all of us. If we can but be subjugated to this monstrous evil, the act of so doing would be but the very beginning of subjugating our entire civilization to the ravages of a ruthless tyranny that would of necessity break down all moral and ethical principles.

Brothers, the gong has sounded. Let us not be on the defensive any longer. Let us launch and maintain an offensive that will eventually overcome this enemy, and then let us bury it in the graveyard that was prepared for us.

This will require concerted action, and believe me, if we want to exist as a freedom-loving profession, it is going to require the aid and assistance of each and every one of you. Let us not forget our humanitarianism, but let us fight this evil thing with every tool at our command.



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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Therapeutic Malignity

SINCE 1955, the American Cancer Society's Committee on New or Unproved Methods of Treatment of Cancer has been performing a quiet, but vitally important service for the medical profession. It is the only agency in the country that compiles a complete and detailed catalog of information on quack treatment of cancer. It makes this information available to medical and legal authorities, and, as a correlated activity, it conducts a continual educational program to protect the public.

Cancer quackery is a particularly vicious form of health fraud. The very thought of the disease sends most patients into a chill of terror, and it must be confessed that there is more than a little justification for panic. Two-thirds of the victims of cancer now die of the disease—even with the best medical care available. The frequency of cancer diagnoses is great, and there is little publicized hope offered that an effective therapy is being developed for many forms of cancer.

The quack, on the other hand, appealing to the hysteria of the patient, often with an admirable "bedside manner," has little difficulty in convincing the victim of cancer, or his family, that he has something to cure the disease of which the medical profession is alleged to be ignorant. The result is a gross waste of the patient's money and a delay in the proper treatment of the disease, if indeed any treatment is at all possible.

In Wisconsin we pride ourselves on the relative sophistication of our population. Nevertheless cancer quackery appears to be widespread in our metropolitan areas, and it floods through our rural areas on a spate of direct mail literature and periodicals.

Unfortunately, it is impossible to stop quacks until they violate a law. We cannot enjoin a man from telling a lie, no matter how monstrous, until the telling of the lie becomes a legally recognized fraud. The Committee, under the aggressive leadership of attorney Francis J. Wilcox, of Wisconsin, is actively engaged in promoting legislation, both state and Federal, to prevent the exploitation of the public in the diagnosis and treatment of malignant disease. But until adequate legislative programs are widespread, the principal activity of the Committee must remain investigative and educational.

It is urged, therefore, that every doctor report immediately any evidence of spurious or quack cures of malignant disease he encounters. A complete description of quacks and quackery, as they appear, with names and address of the chief proponents, their organizations, and a description of the treatment or product, should be sent to the office of the State Medical Society of Wisconsin, which will forward the information to the Committee on New or Unproved Methods for inclusion in the master file. News clippings, reprints, direct mail literature or any other documentary evidence should be carefully collected and sent along with the report.

In addition, doctors should make use of the American Cancer Society's educational material whenever a wave of cancer quackery appears in a community. This material includes booklets, speeches, films and other valuable program assistance.

And finally, as the Committee itself urges, physicians should "provide more adequate care of patients with later terminal cancer because it is, in the main, these groups which unwittingly fall prey to those whose 'cures' have no proven merit."

While few practicing physicians have an opportunity to contribute to the research to develop a universally effective therapy of cancer, we can all assist in the effort to permit the development of cancer research without an incubus of quackery riding on its shoulders. Cooperation with the American Cancer Society and its committees is a significant public service that will, in the long and short run, benefit both the medical profession and its patients.

MATERNAL MORTALITY INSTITUTE

St. Mary's Hospital, Wausau, Wednesday, May 24, 1961

For: Physicians, Hospital Administrators, OB Nurses, Supervisors, and Nurse Anesthetists.

No Registration Fee: Costs underwritten by State Board of Health and State Medical Society.

Moderator: A. H. Stahmer, M.D., Wausau—President-elect, Wisconsin Academy of General Practice

P.M.

2:00—SPECIAL PROBLEMS OF THE PREGNANT DIABETIC

Ben Peckham, M.D., Professor and Chairman of the Department of Obstetrics and Gynecology, University of Wisconsin Medical School

E. S. Gordon, M.D., Professor of Medicine, University of Wisconsin Medical School

3:00—BLOOD PROBLEMS OF SPECIAL SIGNIFICANCE IN PREGNANCY

Tibor J. Greenwalt, M.D., Director, Milwaukee Blood Center and Associate Professor of Medicine, Marquette University School of Medicine

P.M.

3:30—COFFEE BREAK

4:00—TRAUMA DURING DELIVERY AND ITS CONSEQUENCES

T. A. Leonard, M.D., Clinical Instructor in Obstetrics and Gynecology, University of Wisconsin Medical School

4:30—CATASTROPHIC SITUATIONS IN THE DELIVERY ROOM

William Kreul, M.D., Anesthesiologist, St. Mary's Hospital, Racine

5:00—ADJOURNMENT

Academy Credit: 3 Hours of Category I credit for all Academy members who attend.

Program Presented By: State Medical Society of Wisconsin—Wisconsin State Board of Health—Wisconsin Academy of General Practice (Wisconsin Valley Chapter)

Minutes of Council Meeting

Minneapolis, Minnesota, November 4-5, 1960

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 8:30 p.m. on Friday, November 4, at the Hotel Leamington, Minneapolis, Minnesota. Councilors present were Doctors Schulz, Hill, Houghton, Dessloch, Keif, Fox, Bell, Mason, Frank, Ekblad, Egan, Fons, Van Hecke, Kilkenny, Curran, and Past President Hildebrand. Officers and others present were President Sorenson, President-elect Lokvam, Speaker Nordby; Doctors Simenstad and Galasinski, AMA delegates; Gearhart, Chairman, Commission on Hospital Relations and Medical Education (Friday only); Messrs. Crownhart, Thayer, and Toser, Murphy and Robison, legal counsel; Misses Rendall and Pyre.

2. Approval of Minutes of July Meeting

On motion of Doctors Ekblad–Houghton, carried, these minutes were approved as corrected by motion of Doctors Kilkenny–Kief, carried, to show that remarks made by Doctor Fons in discussion of Resolution I were ruled out of order by the chairman. Doctor Fons asked to be recorded as objecting to the minutes of the July 1960 meeting.

3. Guide to Chapter 484, Fee Splitting Statute

Doctor Gearhart reviewed with the Council the Guide prepared at the latters' direction by the Commission on Hospital Relations and Medical Education. After discussion, Doctors Kilkenny–Ekblad moved that the report be accepted. Motion carried.

There was then discussion as to its distribution. Doctors Frank–Kief moved that the Guide be distributed to all members of the State Medical Society. Motion carried.

There was subsequent discussion relative to providing copies of the Guide to other than members of the Society who might wish copies. The Secretary pointed out that had the Council not authorized separate printing, then the Guide would of necessity have been printed in the Journal as part of the Council minutes. The Guide need be included only by reference, to avoid unnecessary expense. However, the Journal is given wide circulation and consequently it seemed best that additional printing of the Guide be provided for new members and to meet anticipated inquiries. After further discussion, the consensus was in favor and no further action was taken.

On motion of Doctors Bell–Mason, carried, the Council approved the Secretary's request that costs of preparing the Guide be charged to the 1961 budget.

4. Report of Scientific Committee of the Council

Doctor Bell, chairman of the Council committee, presented the following report:

At the July meeting, the report of Doctor Lindert, chairman of the Council on Scientific Work, was referred to the Scientific Committee of the Council for consideration and implementation, and report back to the Council.

The report was considered by the Scientific Committee on September 24, followed by a joint meeting with the Council on Scientific Work at which the Council committee reported the following recommendations for implementation which it would report to the general Council; i.e., that

(a) the Council on Scientific Work be renamed the "Commission on Scientific Medicine";

(b) the Council on Scientific Work or the newly designated Commission on Scientific Medicine be named as the scientific committee of the Foundation;

(c) the Council on Scientific Work serve as the coordinator of all scientific medicine within the structure of the State Medical Society and that it assume the responsibility of coordinating the scientific work of the State Medical Society with scientific programs of specialty societies and allied agencies such as the Wisconsin Heart Association, WATA, Cancer Society, and the State Board of Health;

(d) the Council on Scientifific Work make recommendations to the Council relative to the Medical Editor of the Journal and members of the Editorial Board;

(e) the Chairman of the Council on Scientific Work and the next oldest member in service on the Council on Scientific Work, who normally becomes Chairman the next year, meet annually with the general Council at its July meeting;

(f) the Council on Scientific Work make up an annual budget request to be filed by November 1st each year;

(g) the Scientific Committee of the Council be invited to all Council on Scientific Work meetings;

(h) in reference to the enlargement of the Council on Scientific Work, it is recommended that the Council on Scientific Work invite in, on a continuing basis, representatives of specialty societies and voluntary or governmental health agencies who may have an interest in programs for the medical profession.

This should be done on a consultation basis and not designating such invitees as regular

or ex officio members of the Council on Scientific Work (or the newly named "Commission on Scientific Medicine").

Following discussion, on motion of Doctors Bell–Kilkenny, carried, the report was adopted. Question was raised as to the Council's authority to change the name of the Commission on Scientific Medicine. The opinion was given that the Council has interim authority of the House, and since this is a very minor editorial change to avoid confusion of identities, it was felt proper.

5. Report of Planning Committee of the Council

Doctor Frank, chairman of this Council committee, presented the following report:

The committee met on October 16, devoting the meeting to taking inventory of assignments before it. It has two recommendations at this time:

(a) *Law-Science Courses* have been instituted at the Law School of the University of Wisconsin. It is felt that the State Medical Society should cooperate in the development of adequate programs and physician interest.

(b) The Council assigned to the Planning Committee the desirability of continuing an annual *presidents and secretaries conference,* the first of which was held in 1960. The committee recommends to the Council that such a conference be planned for 1961, appreciating that its financing is a matter for consideration of the Finance Committee.

On motion of Doctors Frank–Hildebrand, carried, the report was accepted.

The Council then recessed until 9:00 a.m. Saturday morning, November 5.

6. Report of Executive Committee of the Council

The agenda reported several matters discussed by the Executive Committee since the last Council meeting on which no definitive action was taken, except that in September the committee authorized presentation to the Council of a *review of House of Delegates actions* over the past five years, and the status of their implementation.

Mr. Thayer distributed and discussed this report of 190 actions of the House of Delegates since 1956, except those relating to the insurance programs of the Society, and their status as of November, 1960.

Doctors Hildebrand–Frank moved that actions of the House and a progress report as to implementation be reported to the Council annually. Motion carried.

Doctor Bell stated that he thought the Council and committees should be more cautious in requesting new studies and projects or creating new committees. He felt there might well be a "committee on budget of time and effort" to watch these matters. In discussion, it was brought out that most committees wish to have recommendations to report to the House when some might well report "status quo."

It was moved by Doctors Ekblad–Frank, carried, that this function be left to the Executive Committee of the Council. Motion carried.

Resolutions G–H and I adopted by the House of Delegates, May 1960

Doctor Dessloch then presented a statement and recommendation approved by the Executive Committee of the Council on November 4 after prior approval by the Executive Committee of the Commission on Medical Care Plans:

Vital matters pertaining to the overall policies of Wisconsin Physicians Service can be and are brought before the entire profession of Wisconsin through reports submitted to annual and even special sessions of its House of Delegates.

Wisconsin Physicians Service is unique in this respect. It is under the control and direction of the Society, and is not a separate corporation nor a program run under a self-perpetuating board of control.

The Medical Society of Milwaukee County in the operation of its program has determined to enter into statewide competition with the plan of its parent organization. In a recent editorial in the *Milwaukee Medical Times* it announced its intention to continue that competition unless the State Medical Society and Associated Hospital Service should reassociate.

It was this general problem which was before the House of Delegates in May, 1960. The Council has often expressed its opinion. It has declared that the Milwaukee program, which requires the approval of the State Medical Society, has been approved only for operation within the confines of Milwaukee County. The House of Delegates has approved such statements of the Council. The House has supported the Council in demanding that the Milwaukee program return to its home county. It has agreed that no county society should conduct any functioning operation within the territorial jurisdiction of another county medical society unless with the formal consent of that society and with the approval of the State Medical Society.

No decision of either the Council or the House of Delegates of the State Medical Society of Wisconsin had been complied with by Milwaukee County to the date of the May meeting in 1960.

The Council reached the conclusion that inasmuch as Milwaukee County would not abide by determinations reached in the democratic machinery of the House of Delegates, recourse to assistance of nonmedical machinery was needed, not so much for the sake of the Medical Society as to protect the public interest.

Thus Resolutions G, H and I came before the House. Resolutions G and H were combined and elaborated upon in the Reference Committee. All three resolutions were adopted.

As matters now stand, the controversy has been referred to the Insurance Commissioner. If his decision is nondeterminative, then a management survey of both plans will be undertaken, and included in the survey will be all county societies as well as the state society. During the period of competition by Milwaukee County, councilors from that society are relieved of responsibility for WPS operations, this being the content of Resolution I. This generous treatment of councilors who have disqualified themselves by their position of double allegiance and conflict of interest has been overlooked in the talk which followed.

Now some Milwaukee councilors are demanding that Resolution I in no way be implemented and that they receive any and all information concerning internal operations of WPS which would be made available to councilors other than those from Milwaukee County.

At the July meeting it was suggested that further legal advice be sought.

The Executive Committee points out that there is no conflicting legal advice on the point that directors of competing organizations occupy an untenable position as to confidential information available from either organization. In a statement presented to the House, authored by legal counsel for the Milwaukee society, this legal principle was admitted.

The question is its applicability to given circumstances.

The Executive Committee has discussed examples of what might be considered as confidential material which should not be disclosed to any competitor, whether an insurance company or The Medical Society of Milwaukee County.

These are possible examples:

The State Medical Society utilizes what is known as experience rating in its insurance mechanism. A plant with excellent experience may, under this plan, become entitled to a credit or a refund as against the going-in rate.

Announcing to competitors the fact of such refund would immediately disclose the rate for the following year, thus giving competition an opportunity to underbid.

Conversely, if the rate for the ensuing year is to be increased because that particular installation suffers from poor experience, knowledge of that fact, disclosed to competitors, would enable them to inform the WPS installation even before WPS desired to do so.

Another example of material which in all companies is treated as a trade secret, carefully guarded until such time as planned for public announcement, is a new type of contract and associated rates.

Still another is not to allow some unfavorable experience in a particular line to be known in such fashion that competitors may state that "the financial aspect of the organization is not a happy one."

However unethical and improper such statements may be, however much they may be in violation of law, once made and circulated, defense against them is most difficult. It is the purchasing public which becomes concerned and with which the State Medical Society must deal. Some competition knows that.

All councilors and officers have had the latest available information concerning operations of WPS. Up to the present time there has been no information considered of a confidential character which should not be released. Therefore, Resolution I has not been implemented, and until implemented the principle of law cannot be applied as there are no factual circumstances invoking it. It is premature, to say the least, for representatives of Milwaukee County to protest a situation which has not yet arisen.

Furthermore, the controversy is in the office of the Insurance Commissioner. The Executive Committee is informed that certain legal aspects have been referred to the Attorney General of Wisconsin for advice. These two public officials must assume good faith on the part of the State Medical Society in submitting the matter to their jurisdiction.

It would be unseemly and ethically improper to take steps prejudicial to the Insurance Commissioner and the Attorney General while they have the responsibility of developing ways and means, in the public interest, to solve this particular problem.

Therefore, the Executive Committee recommends that this entire subject be tabled without qualification or restriction.

On motion of Doctors Dessloch–Mason, carried, the recommendation was approved. Doctor Fons asked to be recorded as voting "no."

7. Report of Ad Hoc Committee on the Medical Practice Act and the Title "Doctor"

Pursuant to action of the Council in May, a committee of three physicians had been appointed to meet with the State Board of Medical Examiners concerning the use of the title "doctor."

Distributed with the agenda was a full report of this meeting, to the end result that the State Board would send a delegation to meet with State law enforcement officials, and if this fails, the Board will advise the State Medical Society which offered to send its own delegation.

On motion of Doctors Egan-Curran, carried, the report was accepted.

8. Report of the Commission on Medical Care Plans

Mr. Toser commented on recent mailings to the Council reporting WPS financial information, WPS and Medicare experience statistics, and other matters considered by the Commission at its September quarterly meeting.

On motion of Doctors Hill–Kilkenny, carried, the report was accepted.

9. Inquiry of Speaker Nordby

Doctor Nordby expressed concern that he might be charged with dereliction for not appointing the

study committee referred to in a portion of combined Resolution G–H of the House. Chairman Fox gave what he thought to be the general consensus of the Council that he need have no concern in view of considerations contained in the statement and recommendation approved by the Council that the entire subject of Resolution G–H and I be tabled.

10. Adjournment

On motion of Doctors Bell–Schulz, the Council adjourned at 10:40 a.m.

C. H. CROWNHART,
Secretary

Approved
JAMES C. FOX, M. D.
Chairman

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin.

1. Interprofessional Code

An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

2. Civil Defense Manual for Mobile Medical Team Personnel

An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.

3. Code of Necropsy Procedure

A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

4. Hearing Conservation Programs for Wisconsin Industries

Some recommended standards and principles for providing a hearing conservation program in industry.

5. Occupational Health, A Guide for Medical and Nursing Personnel

General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.

6. Medical Care of Migrant Agricultural Workers

A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.

7. Guide to Immunization Planning

An approved guide including recommended procedures for routine immunizations, parental responsibility, physician responsibility, medical society responsibility and steps for successful community planning.

8. A Guide for Physicians, Hospitals and News Media

A discussion of news relationships between physicians, hospitals, newspapers and radio and television stations. It includes information concerning patients, physicians and county medical society news, health educational efforts and advice on the use of the title "Doctor."

9. Inspection of Medical Records

An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.

10. School Health Examinations

A guide for physicians and school authorities in establishing a program of school health examinations.

11. School Vision Screening Program

An outline to facilitate the development of a program to detect significant visual defects among school children.

12. Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers

A list of the objectives of the State Medical Society in devising the Wisconsin Plan and the conditions under which insurance carriers may participate in that plan.

13. Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959

Relating to fee splitting between physicians and others.

14. The Doctor's Role in Adoptions

A reprint of three Wisconsin Medical Journal articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

NOTE: The January Blue Book issue of the Wisconsin Medical Journal is a handy reference on medico-legal subjects. Keep this issue and refer to it often.

Neurological Hospital Celebrates Tenth Anniversary

A view of the completely remodeled entrance of the Wisconsin Neurological Foundation. The expansion and renovation of the building was begun in 1958.

ONE OF Wisconsin's most unusual hospitals recently observed its 10th anniversary. The Wisconsin Neurological Foundation quietly passed its first decade of service.

During this period, the Wisconsin Neurological Foundation has grown from a 20-bed ward to a completely equipped 60-bed neurological hospital. The patients served during this time have come from virtually every county in Wisconsin and every corner of this nation.

These accomplishments and growths have been significant and of great pride to the many medical and lay people closely connected with the Foundation's work.

In the fall of 1950, a group of doctors and laymen under the leadership of Dr. Edward P. Roemer, 3610 Sunset Drive, a neurologist, organized the Foundation as a nonprofit institution to fill a growing void in medical services.

Most of the effects of neurological diseases and disorders require long-term treatment, special facilities, and rehabilitation.

So, in the following year, a small group of doctors, a nurse, and six other attendants opened a treatment center of 20 beds on the third floor of what was then the Madison Contagious Hospital on East Washington Avenue.

Work was started, on a small scale at first, but growing fast with addition of physical, occupational, and speech therapists, rehabilitation and vocational counseling, and neurological medical facilities.

Concomitant with Foundation development came cooperative programs with the State Division of Vocational Rehabilitation, the Madison School of Vocational and Adult Education, the Madison Public Schools, and the University of Wisconsin.

As the activities of the Foundation steadily expanded, the entire building was purchased from the City of Madison in 1958 to provide a 32–bed unit. More recently has come an $800,000 expansion program to provide a 60–bed capacity in 1960, a program partially supported by the Office of Vocational Rehabilitation, U.S. Department of Health, Education, and Welfare.

Now occupying a large three–story brick building at 1954 East Washington Avenue in Madison, the hospital has a capacity of 60 patients in private, semi-private, and ward rooms. Modern facilities and specialized equipment are provided for the Departments of Neurology, Neurosurgery, Physical Medicine, Occupational Therapy, Psychological Testing, Vocational Guidance, Speech Therapy, Vocational Counseling, Vocational Training, and Recreation. Ancillary facilities include special kitchens, a library, a chapel, a recreation room, workshops, lounges, and an outdoor recreation area, all designed to contribute to the rehabilitation program.

For the in-patient, the larger improved quarters have pleasantly furnished rooms with homelike color schemes, gay drapes, comfortable furniture, all with two-way nurse call systems and even pillow speakers for radio and TV listening. There is a library-lounge with 5,000 books and records and a special kitchen where the patients can brew coffee and make snacks, all part of the 10–year advance.

These are all things that make the unusually long stay at the hospital, averaging 140 days per patient, more acceptable. The Foundation is actually their home for awhile.

The staff now consists of 105 medical specialists, therapists, nurses, technicians, and aids.

But by far, the most significant results of this decade of pioneering may be found in approximately 750 people in all sections of the United States who have been patients at the Foundation.

Other important milestones during this decade have been the recognition of the Foundation as a comprehensive rehabilitation center by the State of Wisconsin Vocational Rehabilitation Division and by the Office of Vocational Rehabilitation of the U.S. Department of Health, Education, and Welfare. It is recognized by these two agencies as the only comprehensive rehabilitation center for in-patients in the entire state.

The Foundation is fully accredited with the Joint Commission on Accreditation of Hospitals. Rehabilitation agencies in 23 other states have working relationships with the Foundation.

THE MEDICAL FORUM

County Society Presidents And Secretaries Hear Reports And Visit State Legislature

MEDICINE'S UNOFFICIAL SPOKESMAN, Dr. Edward R. Annis, Miami, Florida, surgeon, is shown above as he addressed the presidents and secretaries of county medical societies, in Madison, at their annual conference. Also at the speaker's table are C. H. Crownhart, secretary, and Dr. E. D. Sorenson, president, of the State Medical Society.

About 80 physicians attended the Annual County Medical Societies Presidents and Secretaries Conference, held March 22 at the State Medical Society building in Madison.

They observed the legislature in action, met with Governor Gaylord Nelson, heard a talk by Miami surgeon Dr. Edward R. Annis, and received a report from a special State Medical Society delegation to the nation's capital.

The trip to the Wisconsin capitol was arranged to give the county society officers a view of the legislature in action. They heard the Assembly debate the pros and cons of a bill to extend the powers of the State Highway Patrol.

Highlighting the afternoon session, Doctor Annis, "medicine's unofficial spokesman" on the subject of financing medical care for the aged, outlined some of the basic philosophies involved in the current controversy. A report of his talk is given in another article in this issue of the Forum.

The report on the information-gathering trip to Washington contained impressions received in interviews with such national figures as Health, Education, and Welfare Secretary Abraham **Ribicoff**; Dr. Luther **Terry**; Surgeon General, United States Public Health Service; Nelson **Cruikshank**, director of the AFL–CIO department of Social Security; Dr. William S. **Middleton**, medical director of the Veterans' Administration; Wisconsin's Senators and Congressmen, and others.

Doctor Annis Urges Physicians To Speak Out On Aged

"Vigorous fighting for the right is the greatest sport the world affords," said Dr. Edward R. Annis, Miami surgeon, in a talk before the presidents and secretaries of Wisconsin's county medical societies.

An unofficial spokesman for medicine in the current controversy about how to finance medical care for the aged, Doctor Annis invited the individual physicians to join him in this fight, and provided them with considerable ammunition.

Doctor Annis gained nationwide attention through his television debates with Walter **Reuther** of the AFL–CIO and Sen. Hubert **Humphrey**. He once debated two senators at the same time—Jacob Javits of New York and Wisconsin's William Proxmire.

"When it comes to the matter of fundamental principles that are threatening the good of American medicine, we have common interests, common aims, common objectives," he told the physicians at the Annual County Medical Societies Presidents and Secretaries Conference held March 22 in Madison. "And we will only be successful with a united effort."

In making speeches all over the country, physicians often ask Doctor Annis where he gets all the information he uses in his arguments.

(Continued on page 272)

Doctor Annis Urges Physicians To Speak Out

(Continued from page 271)

"Just go home and take those ten packages of magazines off the top and read the last two issues of your *AMA News*," is his reply. "You will have everything I talked about plus a whole lot more."

"You can have a tremendous influence in your civic clubs, your church organizations, your PTA, your scouting work, anything at all that brings you out as an individual physician with other people who get to know and like you as an individual."

"All you have to do is have a few simple answers that are reasonable, that are understandable, and these people will go along with you . . ."

Talking about the King–Anderson bill, presently in Congress, which would use the Social Security mechanism to finance medical care for the aged, Doctor Annis said:

"They are proposing a bill which will take care of the health needs of everyone over 65 years of age, merely because they are over 65 years of age and recipients of social security. That's all you have to do to qualify."

"How many of your friends would be in favor of a tax on the workers and the employers of this country to pick up the grocery bill for all 16,000,000 people over 65 years of age, just because they are over 65?"

"That's socialism; they admit it. How about clothing—same thing."

"So why is it less socialistic to have people have medical care whether they need it or not, or want it or not, or can afford to pay for it or not, if it would be socialistic to provide food, clothing, and housing, merely because they are 65 years of age or older."

As a second reason physicians should oppose the King–Anderson bill, Doctor Annis said, "It is a provision whereby the hospitals shall provide (medical) services."

"They are going to have the hospital provide the services of anesthesiologists, pathologists, physical therapists . . . They make a contract with the hospitals, and the hospitals would provide this care. Not only that, but they are taking advantage of teaching hospital centers, because they also would reimburse them for the services of interns and residents."

A FULL HOUSE listened intently as Dr. Edward R. Annis, Miami, Florida, reviewed some of the current proposals for financing medical care for the aged at the Annual County Presidents and Secretaries Conference at the State Medical Society building in Madison March 22.

"(Secretary of Health, Education, and Welfare) Ribicoff admitted that only those hospitals who would abide by the rules and regulations, the safeguards, the standards, and accept the remuneration established in Washington can qualify under this bill."

Speaking in favor of the Kerr–Mills approach, Doctor Annis pointed out:

"The Kerr–Mills bill taxes everybody in proportion to their ability to pay. The wealthy pay in proportion to their income . . . Who benefits? Only those who need help.

"Under the Social Security program 40 per cent of the nation's income isn't even taxed. Rents, stocks, bonds, oil, these things are not taxed on Social Security—and the man who makes $100,000 pays the same taxes as the man who makes $4,800.

"Who benefits? Everybody who reaches 65 and they receive Social Security, 11 million of them. And four million, who need it most, who are not covered by social security, wouldn't even be helped."

"People approve most of what they best understand," Doctor Annis stated. "So if all they hear is one side of the story, repeated over and over again, and you and I aren't trying to correct that story it's not hard to understand . . . why its easy for them to go along with the contrary point of view."

"Our cause is just," he concluded. "Our success is telling our story to the masses of the American people who are our patients. The future that we pass on shall be an ever enriched heritage of freedom to be passed on to our children and our children's children—if we continue to put forth real effort."

Child Safety Pilot Project

A six-month test panel on child safety will be started soon for all new mothers in Dodge County. The pilot project is sponsored by the Woman's Auxiliary to the Dodge County Medical Society in cooperation with the Wisconsin Council of Safety.

The plan is designed to help mothers and others review the basic safety rules in caring for the baby and also to provide guides for the mother in talking about safety to others.

Safety kits are being distributed through three hospitals in the county with safety suggestions for mothers, members of the family, plus baby sitters. Six weeks later the mother receives a questionnaire which will be used in evaluation of the program.

Committee On Cancer Reports Activities During Past Year

Two major fields of activity in the detection and control of cancer are pointed out in the report of the Committee on Cancer, a Council committee, to the House of Delegates.

The committee has initiated a Cancer Coordinating Committee in cooperation with 13 other agencies, and has urged the Wisconsin Division, American Cancer Society, to place greater emphasis on practical and educational efforts on colostomy care.

Made up of 13 other agencies, both voluntary and public, which have a direct interest in the detection and control of cancer, the Cancer Coordinating Committee lists as its purposes:

1. Review the cancer programs of all participating organizations so as to observe the over-all intent and effect of these programs and to make policy suggestions concerning greater coordination of all activity.
2. Improve liaison between the participating groups.
3. Prevent, to the greatest extent possible, unnecessary duplication and overlapping in the programs undertaken by the participating groups.
4. Suggest and advise the participating groups on means to bring "action" to their programs.
5. Serve as a study and research advisory unit for major problems of cancer detection and control.

The Coordinating Committee will be nonoperational in nature. Its actions will be of an advisory nature at the policy level, involving voluntary coordination by the participating agencies.

In its dual capacity as members of the Medical and Scientific Committee of the Wisconsin Division, American Cancer Society, the State Medical Society committee has urged the Wisconsin Division to:

1. Sponsor programs on colostomy care for nursing schools, surgical nurses, hospital personnel, visiting nurse associations and public health nurses.
2. Increase the number of speakers available to talk to groups of all types on the subject of colostomy care.
3. Expand the availability of information for all groups on colostomy care.
4. Secure a film on colostomy care, since it appears that no professional film is currently available on this subject.
5. Continue the smoking-cancer educational program at the high school level.

PAUL M. CUNNINGHAM, M. D.
Chairman
Committee On Cancer

Cancer In Wisconsin

"Cancer in Wisconsin," a recent publication of the State Board of Health, reveals the following facts:

1. Cancer is now the second leading cause of death in Wisconsin. This is true for three primary reasons:
   a. The number of deaths from other major causes, such as tuberculosis and pneumonia, has been reduced.
   b. The population is aging and cancer occurs more frequently among older people.
   c. Physicians are using modern medical facilities to find cases that previously have gone undetected.
2. Cancer deaths and death rates skyrocket after age 40. Early cancer case finding is important at any age, but it should be given particular emphasis during the critical age period from 40 to 60.
3. At age 65 and over, cancer becomes the third ranking cause of death, with diseases of the heart and vascular lesions affecting the central nervous system ranking first and second.
4. In the age group 1 to 4 years old, cancer is the fourth ranking cause of death, headed only by accidents, influenza and pneumonia, and congenital malformations.

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State Disaster Medical Care In Personnel Training Phase

Wisconsin's plans for medical care occasioned by either military or natural causes are entering a new phase—training of personnel.

This statement is made in the report of the State Medical Society Council's Committee on Disaster Medical Care, which will be presented to the House of Delegates in May.

The report points out substantial progress already made in the appointment of county medical directors, the location of 200–bed emergency hospitals, the establishment of mobile medical teams and the acquisition and placement of emergency medical care supplies.

In announcing the emphasis on training, the committee listed the following accomplishments:

1. **Working closely with the health services section of the state civil defense organization, the committee assisted in the development of the recently revised and approved mobile medical team manual with special emphasis on emergency treatment of disaster casualties. As a means of establishing uniformity of understanding and application of emergency treatment to disaster casualties, the committee wrote into the new manual the American Medical Association's recommendations on this subject.**
2. **The committee also approved publication of a "Lesson Plan —Instruction of Nonmedical Personnel in Emergency Medical Care (20-hour training program)." This training guide will be distributed only to medical personnel and civil defense authorities and will be a major training aid for mobile medical teams and hospital disaster personnel.**

Both of these publications are due to be distributed by early summer of 1961.

Two other developments in the field of civil defense are reported by the committee:

1. **District nurses associations of the Wisconsin State Nursing Association are conducting a series of 20–hour courses over a period of 10 weeks. Physicians will be asked to assist in presenting these training sessions on emergency medical care.**
2. **William Chipman, Madison, has been appointed as the new Director of Civil Defense for the State of Wisconsin. The committee has extended to him a sincere welcome and offered the cooperation and assistance of the State Medical Society of Wisconsin in the development and operation of an adequate and effective program of disaster medical care.**

Civil Defense Law Gives Legal Immunity

Of special interest to physicians is the medical and paramedical immunity protection afforded them under Wisconsin civil defense laws passed by the 1959 session of the Wisconsin legislature.

"Interpretation of these laws makes it clear that physicians are afforded Workmen's Compensation coverage and tort liability protection when they are duly registered in writing with a bonafide civil defense unit," states the report of the Committee on Disaster Medical Care which will be presented to the House of Delegates at the annual meeting.

"Such protection applies whenever they are engaged in authorized training or emergency activities," the report explains.

A full report on the interpretation of this protection will be published in a future issue of the *Wisconsin Medical Journal.*

Report To House Of Delegates By Clinical Medicine Committee

The Committee on Clinical Medicine, created by action of the Council on May 1, 1960, makes the following recommendations in its report to the House of Delegates:

1. **Every county medical society in Wisconsin is urged to give the widest possible promotion to the use of polio vaccine in the spring of 1961 as a safeguard against epidemic.**
2. **A survey be undertaken of Wisconsin blood bank services to determine their ability to provide blood as needed by physicians for the care of their patients.**
3. **Development by the American Medical Association of literature, films and other materials to promote tetanus immunization for the adult. The Committee has been unable to determine that such materials are available at the present time.**

Amplifying its third recommendation, the Committee points to extensive public educational programs against tetanus by several county medical societies, but feels a more widespread program is needed to combat tetanus and the costs and disability attendant upon emergency antitetanus measures.

Another activity of the committee is implementation of Resolution C of the House of Delegates of May, 1960, requesting State Medical Society support for the development of summer camp programs for diabetic children.

Inquiries are being made of those who sponsor camp programs for girls in the western and north central part of Wisconsin to ascertain whether they will accept as many as 15 or 20 diabetic girls.

Should such a camp or camps be willing to cooperate, services of one or more physicians must be arranged on a daily basis to supervise the diabetic control program for these youngsters.

The Wisconsin Diabetes Association will provide a full-time nutritionist-dietician and registered nurse for such camps provided they cooperate in the program. The association also provides financial assistance to youngsters who are unable to pay the cost of staying at such camps.

The major need is for camps which will accept girls, since adequate facilities are already available in Wisconsin for diabetic boys.

REPORT TO HOUSE OF DELEGATES . . .

Reactivate Society Committee On Military Medical Service

After several years on a standby basis, the Committee on Military Medical Service, a Council committee, has been reactivated in view of a pending call of some 250 physicians nationwide for military service.

In its report to the House of Delegates, the committee estimates that Wisconsin will supply perhaps 5 of the 250 physicians.

"The call is necessitated by the failure of a sufficient number of physicians completing their internships to volunteer for duty in the several reserve programs of the Armed Forces," the report states.

"It would appear that the Selective Service call will affect physicians born January 1, 1931, or later, and the necessary physicians will be called on the basis of the youngest first."

Recent contacts with the Department of Defense indicate that physicians may fulfill their military obligation (without subjecting themselves to "draft") by service in reserve units such as the general hospital units in Milwaukee and Madison and medical units of the Wisconsin National Guard.

There are several exceptions to this:

1. In emergency conditions, where requirements of the active Army cannot be satisfied from reserve officers in control groups.
2. If the officer fails to meet the satisfactory participation requirements of attending drills.
3. If the officer has been or is deferred under the Berry Plan and the active Army needs his particular specialty at the time he ends his residency and deferment.
4. If the officer is subject to active duty as a result of completing the advance course ROTC.
5. If the officer is commissioned after being ordered to active duty.

F. L. WESTON. M. D.
Committee Chairman
Military Medical Service

Physicians who are liable for involuntary active duty may therefore avail themselves of this opportunity by applying to a reserve or national guard hospital unit with a position vacancy. If accepted they will be commissioned and assigned to the unit.

Dane County Health Fair

A Dane County Health Fair, to be held in May of 1962, was approved March 14 by the Dane County Medical Society.

Society officials called it "the most ambitious project ever contemplated by the society." The primary purpose will be to interest young people in careers in medicine and allied fields. In addition, exhibits relating to all phases of medical activity will be presented for general interest.

Four basic divisions are planned. One will be a hospital corridor, depicting the various activities of an average hospital. Another will be a career section with exhibits on medicine, dentistry, x-ray, dietetics, occupational therapy, and other careers related to health care.

A third section will contain exhibits by the various health agencies at work in Dane County and a fourth will be made up of general exhibits from the American Medical Association.

On the committee planning the health fair are Dr. J. F. McIntosh, Dr. Charles A. Doehlert, Jr., Dr Richard J. Botham, Dr. Charles K. Kincaid, and Dr. P. B. Golden.

The fair will be free to the public. To finance the event, an assessment of $15 per member was voted by the society.

HOLD PANEL DISCUSSION ON MEDICAL EDUCATION

Dean John Z. Bowers, three University of Wisconsin Medical School faculty members, and a medical student took part in a panel discussion on medical education on the univerity campus March 15.

Purpose of the panel was to give undergraduates information on the medical school and problems they will face if they attend.

Doctors Bowers moderated the panel and participants were Dr. Otto A. Mortensen, Dr. Robert D. Coye, Dr. David W. Smith, and Mark C. Kiselow, third-year student.

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House Receives Eleven Recommendations Of SMS Commission On State Departments

The House of Delegates, meeting in Milwaukee in May, will receive eleven recommendations from the Commission on State Departments of the State Medical Society.

The major recommendations are summarized as follows:

1. A statewide conference on home care programs be developed by the State Medical Society of Wisconsin in cooperation with state and voluntary agencies to be held during 1961.

2. The State Department of Public Welfare be encouraged with the active assistance of the Division on Nervous and Mental Diseases to establish a series of workshops for physicians, county board members, trustees, hospital administrators and social workers involving didactic and clinical discussions of the care of patients in county mental hospitals.

3. The two Wisconsin medical schools be urged to develop more comprehensive undergraduate and postgraduate training regarding the medical use of hypnosis.

4. All physicians, in the interest of obtaining the utmost in professional understanding, be urged to attend a conference on the medical aspects of mental retardation to be held at Brooks Memorial Auditorium at Marquette University, Milwaukee, on Wednesday, June 21.

5. All physicians use the "Prenatal Facts" form in their obstetrical work, participate in special conferences arranged by the Division on Maternal and Child Welfare, utilize teaching tapes prepared by the Maternal Mortality Study Committee and conduct local studies on neonatal and perinatal deaths.

6. Emphasis be placed on securing earlier diagnosis of cancer, particularly in children, with a view to the application of the newer forms of cancer therapy, especially valuable to the younger person.

7. All medical staffs of hospitals study carefully the Wisconsin Administrative Code of the State Board of Health for maternity hospitals and establish mechanisms to implement these rules and regulations locally.

8. Approval be given to the recommendations of the Division on Chest Diseases of the Commission on State Departments regarding the dual use of institutions for the care of the tuberculous and nontuberculous patients. In summary these recommendations are:

a. Admission policies in all institutions operating in a dual capacity should be determined in cooperation with the local county medical society.

b. County medical societies should establish a county medical advisory committee to assist the county board, instruct trustees and the medical director in the establishment of admission policies, visiting staff appointments and physician treatment privilege. It should meet periodically with the trustees and medical director of the institution, make an annual report on the operation of the institution to the county medical society and serve as a liaison committee to review complaints concerning professional relationships and medical practices in the institution.

9. Extensive mass screening of potentially exposed persons be undertaken by the county medical society in cooperation with public health authorities in any school or similar situation where a known case of tuberculosis has been revealed.

10. The standards for tuberculin testing recommended by the Division on Chest Diseases be approved.

11. In light of all known factors it is recommended that county medical societies cooperate with the State Board of Health in furtherance of the hypertension screening program, and that in planning the program on a county level a small committee of the county medical society work with representatives of the State Board of Health to set up procedures for reporting and follow-up which are consistent with the resources and the experience of the county medical society in other areas of public health.

a. The concept of "public health" is changing, and the practice of medicine should consider its proper role in a situation where true public health is more than the checking of communicable disease. The facilities of public health are ideally suited for mass screening programs which can be of tremendous service to citizens and physicians alike if properly correlated with the private practice of medicine, and cooperative medical programs developed on a local and/or county level.

b. The early detection of hypertension can be attained through mass screening techniques, and can logically be coordinated with a chest x-ray program, originally designed to detect tuberculosis.

c. Blood pressure readings are admittedly variable, and often reflect the condition of the patient at the particular moment the reading is taken, with marked variation at other times, but in spite of this an elevation of blood pressure *may* indicate an early case of hypertension which, if properly treated, may save the patient's life.

BOARD OF HEALTH HAS EXHIBIT ON INFLUENZA

"Stop Needless Deaths from Influenza by Immunization" headlines the top of an exhibit which may be borrowed for professional meetings from the State Board of Health. The exhibit was prepared by the Communicable Disease Center, Atlanta.

It points out that excess deaths due to pneumonia-influenza occur among persons 65 and over, pregnant women, and the chronically ill. Initial immunization of 1.0 cc. (500 cca units) of polyvalent vaccine, administered subcutaneously on two occasions separated by two or more months is recommended for adults.

The exhibit is mounted on three 22 inch x 28 inch heavy cardboard panels hinged together for tabletop display. It may be borrowed from the State Board of Health, Madison 2.

Internship Program In Wisconsin Is Subject Of SMS Sponsored Conference On May 20

A conference on the internship program in Wisconsin hospitals will be held Saturday, May 20, at the State Medical Society building in Madison.

Sponsors of the conference are the Commission on Hospital Relations and Medical Education of the State Medical Society, through the Charitable, Educational and Scientific Foundation, and the Council on Medical Education and Hospitals of the American Medical Association.

Meeting with these two groups will be representatives of the 22 hospitals in Wisconsin directly concerned with the internship program. They will be discussing methods to improve the internship situation in the state.

The day-long program will start with registration at 9:30 a.m. Dr. Robert S. **Gearhart**, Madison, chairman of the Commission on Hospital Relations and Medical Education, will be moderator.

At 10:30 a.m. Dr. Leland S. **McKittrick**, Boston, chairman of the Council on Medical Education and Hospitals, American Medical Association, will discuss "The Internship: Educational Content and Type." Doctor Gearhart will be the discussant.

Dr. James **Campbell**, Chicago, a member of the board of directors of the National Matching Program of the Council on Medical Education and Hospitals of the AMA will discuss "The Matching Program for Interns" at 11:30 a.m. Dr. Robert W. **Byrne**, Milwaukee, will be the discussant.

At 2:00 p.m. "The Responsibilities of the Directors of Education and the Hospital Staff for Interns" will be discussed by Dr. Richard **Saunders, Jr.**, New York City, associate dean of Cornell University Medical College. Dr. R. E. **McMahon**, La Crosse, will be discussant.

At 3:00 p.m. George E. **Cartmill**, director, Harper Hospital, Detroit, will discuss "The Hospital Administrator and the Internship." Warren **Von Ehren**, Madison, executive director of the Wisconsin Hospital Association, will be the discussant.

The session will end with a general question and answer period.

MEETING GOVERNOR GAYLORD NELSON is Dr. Eugene J. Hohler, Mineral Point, secretary of the Iowa County Medical Society. Looking on are the presidents and secretaries of other county societies who also met the governor and observed the legislature in action during their annual conference.

THE LEGISLATURE IN ACTION was viewed by county medical society presidents and secretaries. They are pictured above in the Assembly gallery as they listen to a debate on increasing the powers of the state highway patrol.

Special Event For Tennis Enthusiasts

For the tennis enthusiasts who plan to attend the SMS annual meeting there will be an extra attraction on Monday evening, May 1. Jack Kramer's World Series tennis event will be held in the Milwaukee arena starting at 8 p.m. Details on the event and ticket reservations appear on page 28 of this issue of the *Journal*.

WISCONSIN PHYSICIANS SERVICE ANNOUNCES . . .

Major-Medical Enrollment Is Up 65 Per Cent For The State of Wisconsin Employee Group

An estimated 28,000 State of Wisconsin employees and members of their families will be protected by Wisconsin Physicians Service major-medical coverage effective May 1.

As WPS enters its second year offering major-medical coverage to the state employees, the total figure shows an increase of approximately 65% in the estimated number of individuals covered.

Some 6,724 contracts, covering an estimated 16,810 members, were renewed April 1. These are the individuals who are carrying the WPS major-medical health protection for the second year.

Due to an open enrollment of new members from February 1 to March 28 this year, another 4,451 contracts are expected to go into effect on May 1. These new enrollments cover an estimated 11,127 employees and members of their families.

All of the state employees who are enrolled under the major-medical contract also carry WPS basic surgical-medical coverage.

Cites Marquette Need For Hospital Facilities

Marquette University School of Medicine needs its own hospital, where paying patients can be treated and can participate in teaching and research, Dr. John S. *Hirschboeck* told the Milwaukee County Medical Society at its January meeting.

Doctor Hirschboeck, dean of the medical school, said Marquette is one of only five or six medical schools in the country without its own hospital.

"Highroad To Health" On Thirteen Radio Stations

A transcribed radio drama-interview series, "Highroad to Health," will be broadcast over eight Wisconsin radio stations, according to an announcement by Lederle Laboratories, which produced the series.

Cite SMS Support Of Local Public Health

In a recently published pamphlet on public health organization, the Wisconsin State Medical Society is singled out as an example of how medical organizations can support effective public health organization.

The publication, entitled "Your Neighbor's Health Is Your Business," states: "The Wisconsin State Medical Society, for example, has declared, 'The establishment, at the earliest possible date, of local, county, and district or regional full-time health services is deemed in the public interest and consistent with the Society's program.' "

The booklet is published by the Public Affairs Committee, Inc., as Public Affairs Pamphlet No. 180.

Mental Health Act Study Set

Three physicians have been named by the Wisconsin Mental Health Advisory Committee to a nine-member committee which will review the State Mental Health Act.

The committee said it has found that many persons who work with the act "believe it has not kept up with the rapid advancement in treatment and changes in public attitude toward persons with mental handicaps."

The newly appointed group will review judicial commitments of the mentally ill, voluntary admission to mental hospitals, rights of committed persons and the interstate compact on mental health.

Physicians serving on the review group are Dr. Leonard Ganser, Madison, director of the division of mental hygiene of the Department of Public Welfare; Dr. Charles Landis, Milwaukee, director of mental health, Milwaukee County Institutions and Departments; and Dr. Edward Schwade, Milwaukee, chairman of the division on nervous and mental diseases of the Commission on State Departments of the State Medical Society.

Medical–Legal Clinic Is Held

A day long medical-legal clinic was held April 22 in Eau Claire under sponsorship of the committee on postgraduate education of the State Bar of Wisconsin, in conjunction with the Eau Claire County Medical Society and the Eau Claire County Bar Association.

Dr. John H. Wishart, Eau Claire, presided and opened the clinic with a talk on "Interprofessional Relationship."

Discussing "Skeletal Injuries" were Dr. Harold E. Sorensen, Dr. Charles M. Ihle, and Dr. Thomas E. Kilkenny, all of Eau Claire. Dr. Ralph C. Frank and Dr. Thomas D. Moberg, both of Eau Claire talked on "X-Ray Interpretation."

Dr. Horace S. Fuson, Eau Claire, discussed "Interpretation and Use of Medical Records," and a panel of physicians and attorneys answered questions to complete the morning program.

In the afternoon Dr. Albert A. Lorenz, Eau Claire, discussed "Psychiatric Aspects of Trauma" and Dr. James W. Merritt and Dr. James B. Dibble, both of Eau Claire, talked on "Cardiovascular and Pulmonary Injuries." A panel discussion completed the afternoon session.

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Lymphangioma in Unusual Sites: Spleen, Mesentery, Retroperitoneum, Mediastinum and the Greater Omentum

By DUANE L. LARSON, M.D.; BYRON A. MYHRE, M.D.; ERWIN R. SCHMIDT, M.D., and WALTER H. JAESCHKE, M.D.

Madison, Wisconsin

LYMPHANGIOMA is defined as a circumscribed enlargement and new formation of the lymphatic vessels, that is, a tumor composed of lymphatics. The most common location for lymphangioma is the neck, where it appears as a cystic hygroma. However, other sites are occasionally involved. Our interest in this subject was stimulated by a number of instances of lymphangioma in unusual locations.

Lymphangiomas were found in the region of the foramen magnum, conjunctiva, lip, cheek, extremities, tongue, nose and axilla. In one case, a 15-year-old girl was admitted with the diagnosis of an indirect inguinal hernia. However, this turned out to be an egg-sized lymphangioma located at the internal inguinal ring. Another interesting case was that of a young woman with a diagnosis of a blue dome cyst of the breast which was found to be a small lymphangioma.

The case histories will be briefly described.

Case Reports*

Case 1. Perirenal and posterior mediastinum.

A two-year-old white girl was admitted to the hospital with a large intra-abdominal mass. Four months prior to admission the child had urinary frequency, dysuria, and enuresis of one week's duration. One week prior to admission, she developed mid-abdominal and anterior chest pain which occurred intermittently throughout the day. The mother noted a mass in the right side of the abdomen.

A large, soft mass was palpated in the right upper quadrant of the abdomen. The diagnosis was Wilms's tumor or neuroblastoma.

At surgery a large, cystic mass was seen arising from the right kidney area. This mass occupied much of the lateral, upper, and medial surfaces of the right kidney and contained 200 cc. of brown fluid. A right nephrectomy was done in order to completely excise the cystic lesion.

The inner surface of the cyst was roughened and hemorrhagic. The microscopic examination revealed thickened, cavernous lymph vessels with some hypertrophied smooth muscle (Fig. 1). There were scattered collections of lymphocytes. The histologic diagnosis was perirenal cavernous lymphangioma.

Four months following her initial admission, the child was readmitted for excision of a mediastinal mass, previously noted on a chest x-ray during her

* From University Hospitals.

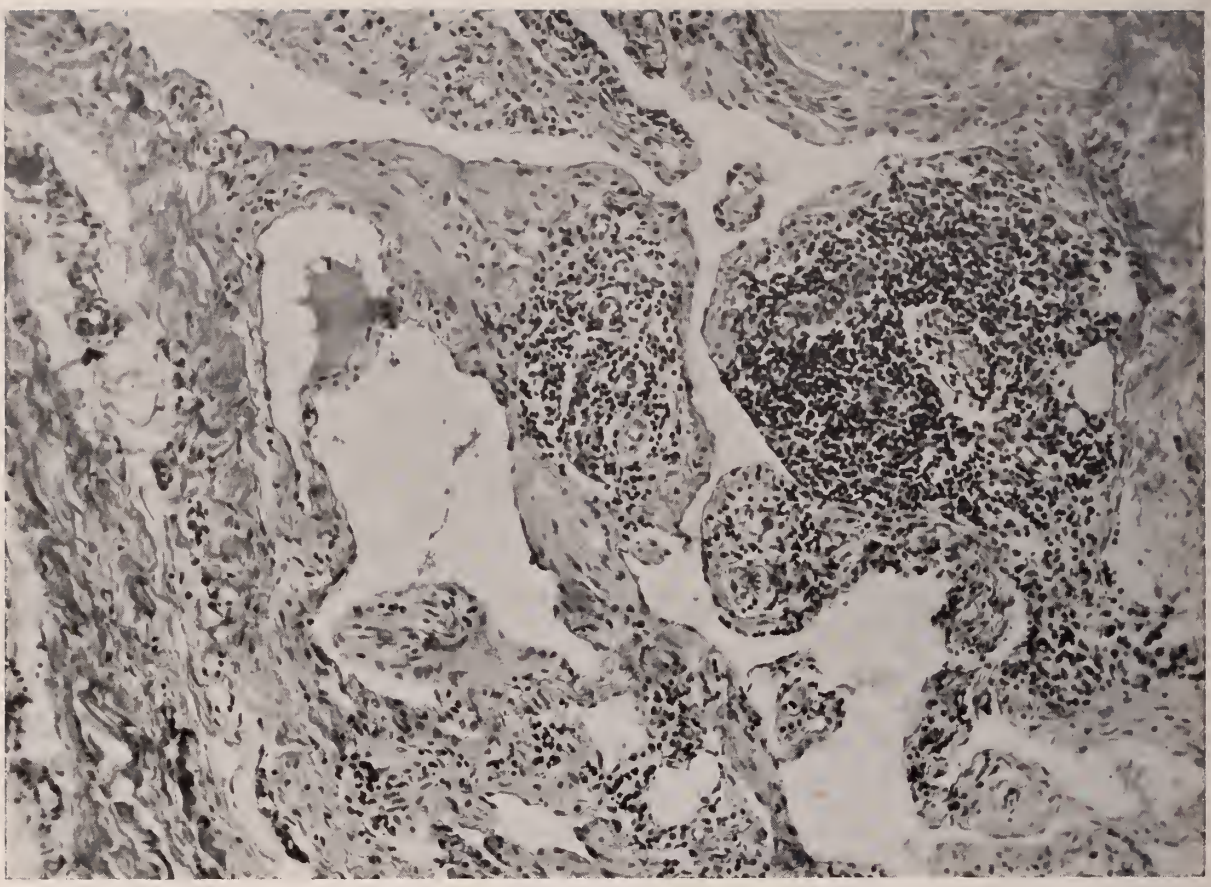

Fig. 1—Microscopic view of perirenal lymphangioma in Case 1.

first admission (Fig. 2). At surgery a large, blue-gray cyst was found in the posterior mediastinum, arising above the aortic arch level and extending down to the inferior pulmonary ligament (Fig. 3). This cyst contained thin, cloudy fluid with scattered, minute, yellow particles. The microscopic examination revealed the wall of the cyst to be formed of smooth muscle and connective tissue elements (Fig. 4). It was lined by endothelium which contained small lymphocytic aggregates. The diagnosis was cystic lymphangioma of the posterior mediastinum.

Case 2. Superior mediastinum.

A 23-year-old white woman was admitted because of an asymptomatic mediastinal mass seen on a routine chest film. On deep inspiration, with fluoroscopy, the superior mediastinal mass was seen to narrow in the transverse diameter and become more rounded in expiration. The preoperative diagnosis was congenital mediastinal cyst. At surgery a 10 cm. cystic tumor was excised from the right superior mediastinum. The pathologic diagnosis was cystic lymphangioma.

Case 3. Posterior mediastinum.

A 27-year-old white woman was admitted for a resection of a thoracic aortic aneurysm. At surgery an incidental finding was a small lymphangioma near the proximal portion of the descending aorta.

Case 4. Spleen.

A 52-year-old, married, white woman was admitted with the diagnosis of carcinoma of the pancreas. Four months previous to admission there was an insidious onset of intermittent, left costovertebral back pain which increased in frequency and duration, remaining constant the four weeks prior to admission. The pain increased when the patient was in a supine position and was somewhat relieved by a sitting position. This patient also suffered a 17-pound weight loss in the four months' period.

At surgery no pathologic condition was seen in the abdomen except for that associated with the spleen. The spleen was enlarged and covered with hard, yellowish-white nodular lesions measuring 0.3 cm. to 1.0 cm. in diameter. On miscoscopic examination the nodules consisted of dilated, closely spaced lymph vessels and multiple perivascular fibrous foci. The remaining splenic tissue was not especially remarkable, although many small vessels were moderately thickened. The diagnosis in this case was multiple lymphangioma of the spleen.

Case 5. Mesentery.

A 46-year-old white man two days prior to admission had an exploratory laporatomy performed by his local physician for an "acute abdomen," at which time a large neoplasm was found. The abdomen was closed and the patient was referred to our hospital.

Prior to his initial surgery he had had severe right upper quadrant and right lower quadrant cramping pain with marked abdominal tenderness and muscle guarding. No history of nausea, vomit-

Fig. 2—X-ray film showing mediastinal mass in Case 1.

Fig. 3—Cut specimen of mediastinal mass in Case 1.

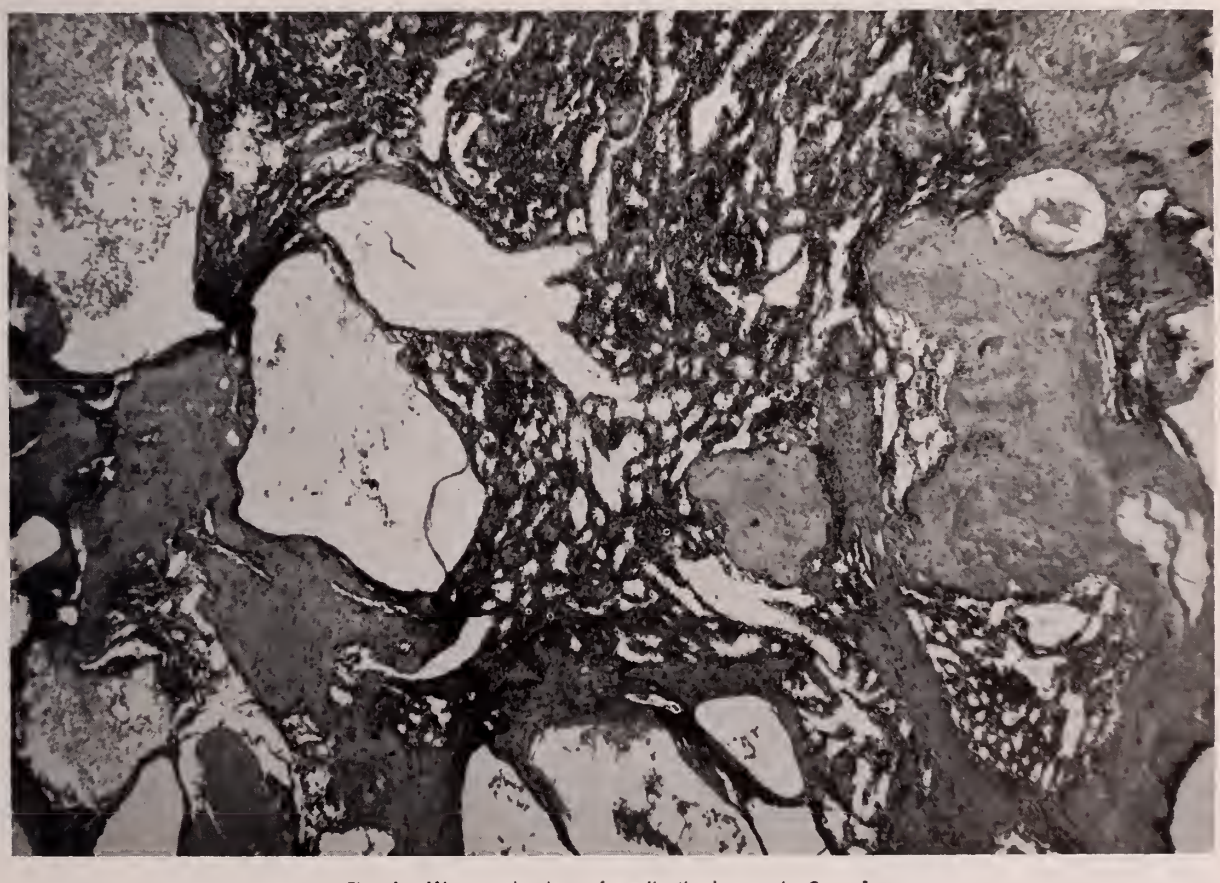

Fig. 4—Microscopic view of mediastinal mass in Case 1.

Fig. 5—Upper gastrointestinal series in Case 8 showing displacement of the sigmoid and the small intestine out of the pelvis.

Fig. 6—Cut specimen of the lymphangioma of the greater omentum in Case 8.

ing, diarrhea, constipation, fever, sweats, or chills was elicited.

The second exploration of the abdomen revealed a large, cystic mass involving the main vessels of the right colon and cecal area. In order to excise this mass, it was necessary to resect the terminal ileum and ascending colon and to perform an ileotransverse colostomy.

The mass from the mesentery measured 10 cm. x 5 cm. x 5 cm. It consisted of soft yellowish–brown connective tissue enclosed in a thin serous membrane, and it had a moist cut surface. In one portion of the specimen there were some cystic spaces containing clear serous fluid, the largest of which was 3 to 4 cm. in diameter. Microscopically the mass was composed of fatty connective tissue, numerous blood vessels, and multiple large dilated lymph spaces lined with endothelium.

Case 6. Retroperitoneal.

A three-month-old white boy was admitted with a large, soft mass in the right flank which had been present since birth. The mass was 18 by 20 cm. and extended from the right axilla to the right iliac crest. At surgery the mass was found to extend retroperitoneally. The diagnosis on microscopic examination was lymphangioma.

Case 7. Retroperitoneal.

A 2-year-old white girl was admitted for excision of three masses which had been present since birth. One was in the right lower quadrant, another in the right inguinal area and the third in the medial aspect of the right thigh. They were asymptomatic but had increased in size over a two months' period. At surgery the inguinal mass was found to extend retroperitoneally. The three lymphangiomas were excised in three stages.

Case 8. Greater omentum.

A 32-year-old athletic, white man was admitted with a diagnosis of a possible pelvic mass. Two months prior to admission he had developed a dull aching pain in the left testicle which lasted for two days. Four days later he noted a tickling sensation at the right of the umbilicus with radiation to the right lower quadrant. Three weeks before admission, he developed an intermittent mild lumbar pain which seemed unrelated to the abdominal complaint. At his local hospital, x-rays of the gallbladder and an intravenous pyelogram were negative; however, the upper gastrointestinal and colon x-rays showed displacement of the sigmoid and small intestine out of the pelvis (Fig. 5). Physical examination was completely negative.

At surgery a 17 x 23 x 5 cm. multiloculated cystic mass containing dark brownish–black fluid was found in the lower portion of the greater omentum (Fig. 6). Microscopic examination revealed irregular, thin-walled cysts filled with xanthochromic fluid (Fig. 7). Microscopically the omentum contained

large, tortuous, endothelial-lined spaces with groups of lymphocytes in subendothelial locations. The diagnosis was cystic lymphangioma.

Etiology

In order to fully understand this lesion, the lymphangioma, one must consider briefly the development of the lymphatic system.

There are two theories regarding the development of lymph vessels. One is that they are originally independent formations which secondarily acquired connections with the vein. The other is that they are derived primarily from the veins as endothelial outgrowths.

Arey[1] believes lymphatics develop independently of blood vessels. They originate as discrete spaces in the mesenchyme, when the mesenchymal cells bordering each space flatten into an endothelial lining. By progressive fusion such locally formed clefts link into continuous channels which also grow, branch and extend the system farther. The first plexus of lymphatic capillaries is distributed along the primitive main venous trunks. The dilatation and coalescence of this network at definite regions give rise to five lymphatic sacs: paired jugular sacs lateral to the internal jugular veins, an unpaired retroperitoneal sac develops at the root of the mesentery adjacent to the suprarenal glands, and paired posterior sacs arise in relation to the sciatic veins. Thus lymphatic vessels grow to the head, neck, and arm from the jugular sacs; to the hip, back and leg from the posterior sacs, and to the mesentery from the retroperitoneal sac. The jugular sacs are the only ones to acquire permanent connections with the venous system. The various sacs, themselves, are eventually replaced by chains of lymph glands.

According to Sabin,[2] the lymph sacs develop as outgrowths of the endothelium of the veins near which they appear, and from these sacs all lymph vessels of the body sprout.

Whatever the origin of these sacs, there is agreement about their position and their subsequent history. The lymphatic sacs, by a process of bridging or by a process of cutting of the lumina by bands of connective

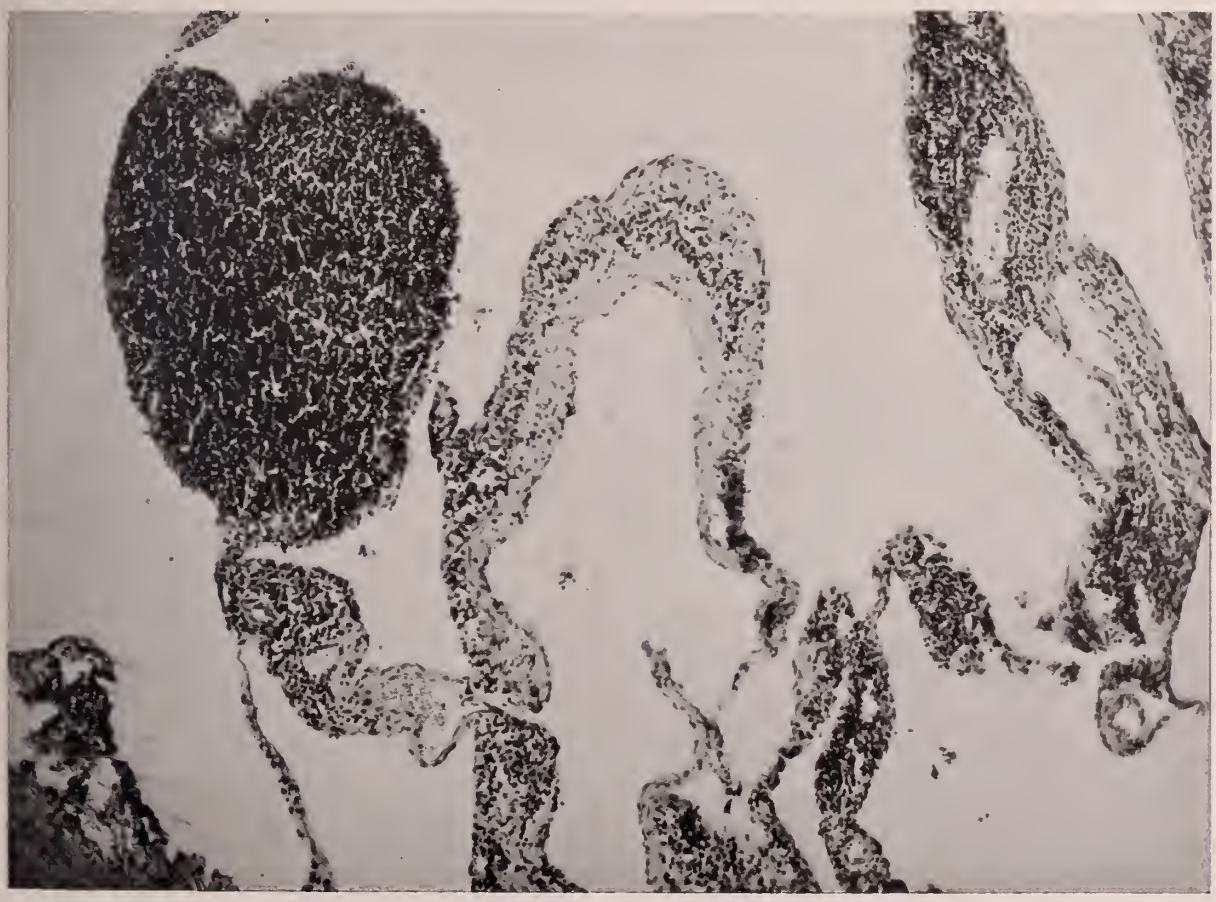

Fig. 7—Microscopic view of lymphangioma of the greater omentum in Case 8.

tissue, are transformed into a plexus of lymphatic capillaries out of which chains of lymph nodes are evolved. If this stage of development of a particular lymph node is arrested at a stage when it is still a plexus, we have the basis for the development of a future cyst. The fact that these lymphangiomas arise in areas corresponding to primitive lymph sacs points strongly to these structures as the embryologic site of their origin.[3]

Goetsch[4] concluded that a portion of the primitive sac may be sequestrated and fail to establish communication; then subsequently, the sequestrated part may continue to grow in a manner characteristic of the primitive lymphatic system. Concurring with this opinion, Childress et al.[5] states that the final position of the lymphangioma is determined by the destiny of the structures to which the displaced primitive lymphatic sac is adherent. The majority of authors tends to accept the theory that lymphangiomas are congenitally misplaced lymphatic tissue.

Incidence

A review of the literature indicates that intra-abdominal lymphangiomas are very uncommon. Watson and McCarthy[6] reported 1,056 tumors of blood vessels and lymphatics. They found only 41 lymphangiomas, none of which was intra-abdominal. Raiford[7] found only one lymphangioma of the abdominal viscera in 11,500 postmortems.

Harrow[8] found only 15 cases of retroperitoneal lymphatic cysts reported in the literature, including his own. His criteria for classification required that these cysts should contain most of four identifying elements to differentiate them from other types of cysts: (1) The lining of the cyst should be endothelial (or absent) and must not be cuboidal or columnar epithelium; (2) Small lymphatic spaces, numerous in some areas, should be found in the wall; (3) Lymphoid tissue should be fairly abundant in the wall as diffuse collections of lymphocytes or as configurations similar to true lymph nodes and (4) Foam cells containing lipoids may exist in varying numbers.

Fowler[9] stated there were 265 cases of nonparasitic, benign cystic tumors of the spleen reported in American and foreign literature up to May, 1952. Of these, 110 were primary cysts (27 lymphangioma, 48 hemangioma, 2 dermoid, 23 epidermoid, and 10 endothelial-lined).

Childress et al.[10] found 17 cases of lymphangioma of the mediastinum, and they added one more case to make the total 18. Higgins et al.[11] listed only 2 cases of isolated renal lymphangioma and 1 other case, originally reported by Denis Brown, which was a simultaneous renal and mediastinal lymphangioma such as was reported in Case 1.

Pathology

Microscopically, lymphangiomas are made up of three different groups:

1. *Lymphangioma simplex* is an uncommon, poorly defined disease entity which borders on simple lymphangiectasia. It is a circumscribed swelling with an ill-defined margin, composed of dilated lymph vessels, with a richly cellular connective tissue stroma. It is usually seen in infants and children, involving the skin and subcutaneous tissue of the face or neck and appears as purplish–red skin vesicles. It shows little tendency to grow.
2. *Lymphangioma cavernosum* usually constitutes the majority of lymphangioma cases. This form is composed of dilated lymphatic sinuses usually filled with lymph, but sometimes empty, and in rare instances filled with blood. It usually involves the skin or subcutaneous tissues, but it may extend into mucous membranes of the oral cavity or between the muscle septa of the neck. The superficial skin lesions appear as multiple brownish or red vesicopapules, or even wart-like papillary lesions. The deeper growths present an appearance of multiple, diffuse, compressible nodules or masses with little or no change in the overlying skin.
3. *Lymphangioma cysticum* is characteristically a thin-walled cystic structure lined by endothelium. Although occasionally unilocular, the subsidiary cysts have a variety of sizes and shapes. The cysts may intercommunicate or may be separated by fibrous septa. The multilobulated gross appearance of the cysts is caused by these septa. Puncture of one portion of the mass with release of fluid may or may not result in collapse of the entire structure depending on the degree of completeness of compartmentation. The fluid is usually thin and colorless. When there has been super-

imposed hemorrhage, the fluid may be xanthochromic or frankly bloody.[12]

A variety of structures may be incorporated into the cyst wall, such as connective tissue, smooth muscle, fat, blood vessels, and nerves. Goetsch suggests this may be due to the type of growth pattern, i.e., the lymphangioma enlarges by a process of endothelial sprouting which extends along tissue planes. Foreign elements, thus, can be surrounded by the cystic prolongations.

If a cyst of this nature is aspirated, it refills slowly; if it is excised, it is not followed by escape of chyle; and if it is marsupialized, it does not drain chyle. Therefore, Ackerman[13] concludes lymphangiomas probably have little or no connection with adjacent normal chyle-bearing lymphatics.

Clinical

The clinical picture of lymphangioma varies considerably, depending upon numerous factors such as size of the tumor, location, presence of infection, twisting of the tumor pedicle, traumatization of the cyst, or presence of bleeding or rupture. Symptoms produced by these cysts are not pathognomonic.

The majority of the lymphangiomas occurs in the early years of life; however, they may be found at any age. Eichwald[14] reported the finding of a cyst of this type in an infant, three weeks old, and Horgan[15] found one in a man aged 76.

The cystic lymphangioma can, on occasions, reach large proportions. Hardaway[16] reported a cyst of the omentum in a four-year-old girl; it measured 25 x 20 x 10 cm., weighed 2,600 gm. and contained 2,500 cc. of amber fluid. The largest lymphangioma in our series was that of the omentum which was multiloculated and measured 17 x 23 x 5 cm.

Montgomery and Wolman,[17] in reviewing 53 cases of lymphangioma of the omentum, divided them into three main categories based on symptomatology. In group 1, the largest group, containing 42 patients, symptoms were due to the size of this tumor. In group 2, made up of 6 patients, symptoms were produced by twisting of the pedicle or rupture of the cyst. Group 3 contained 5 patients who were asymptomatic. Our patient (Case 8) with the omental lymphangioma would fall into Group 1, since his vague symptoms were most likely secondary to the size of the tumor. The fluid in the cyst was xanthochromic presumably because of previous hemorrhage into the cyst. This could have produced distention and symptoms similar to his presenting complaints.

Occasionally torsion of an abdominal cyst on its pedicle may produce acute symptoms. Arata and Blanchet[18] reported a case occurring in the omentum which simulated an acute appendicitis. The case presented here had no evidence of this having occurred.

Lymphangioma in the mesentery may also undergo torsion or produce an intestinal volvulus. They may rupture into the peritoneal cavity and simulate acute peritonitis or a ruptured tubal pregnancy. There may be slow hemorrhage into the cyst over a long period, producing the picture of secondary anemia. Infection may develop and present a picture of an acute appendicitis or diverticulitis.

McNab and Menzies[19] reported a case of an 18-year-old man with an intestinal obstruction, secondary to involvement of two feet of ileum with a lymphangioma. Walker and Cooper[20] reported a similar case of a 32-year-old man who had hemorrhaged into a lymphangioma of the ileal mesentery.

The symptoms of Case 5, with a mesenteric lymphangioma, were most likely secondary to involvement of the vascular supply of the distal ileum, cecum, and ascending colon by torsion. Waters[21] stated that one-third of mesentery lesions such as this produce intestinal obstruction; however, there was no encroachment of the intestinal lumen in this case.

Retroperitoneal cysts are frequently asymptomatic and are discovered only because of a palpable abdominal mass. Gerster[22] indicated that if symptoms are present, a gradual onset is the rule. There is loss of weight, vague digestive disturbances, increasing constipation in some cases, and an increase in the size of the abdomen. Usually the retroperitoneal mass lies above the umbilicus to the right or left of the midline. In the patients in Cases 1 and 4, the lymphangioma of the spleen and right perirenal area were symptomatic; however, the other two cases of retroperitoneal lymphangioma (6 and 7) were asymptomatic.

Wynn–Williams and Morgan[23] described a patient with lymphangioma of the kidney whose chief complaint was hematuria. A lymphangioma of the ureter was reported in a 79-year-old man by Jeppesen.[24] The patient in Case 1, involving the right renal area and

mediastinum, had some symptoms of urinary frequency, dysuria, enuresis, and left lower quadrant abdominal pain which radiated to the left flank. These symptoms could be secondary to the irritation of the tumor. Although it did not involve the renal parenchyma, the tumor was intimately connected to the right kidney.

The chief symptoms of splenic lymphangioma, when they occur, are pain and swelling beneath the left lower ribs. The pain varies and may express itself as a feeling of heaviness or of a dragging character. It is located in the left hypochondrium or referred to the epigastrium and, at times, to the left scapular area. Loss of weight and strength occur when the growth is large. Fowler, in a review of 27 splenic lymphangiomas, found there were no symptoms from small cysts; however, large cysts caused symptoms from pressure on neighboring organs with resulting dysfunction.

It is understandable that the patient in Case 4 (splenic lymphangioma) was referred with the diagnosis of carcinoma of the pancreas since all of the symptoms she presented are frequently associated with neoplasms of the pancreas.

The diagnosis, preoperatively, of intra-abdominal lymphangioma is almost never made due to the variable nonpathognomonic picture presented. Birnkrant[25] has stressed roentgenologic examination of the abdomen as a valuable aid in the diagnosis; but in general, laboratory procedures do not give specific information. They help only in revealing a space-occupying lesion.

Our three cases of mediastinal lymphangioma, like most lymphangiomas, presented a variable picture. Case 3 was discovered incidentally during surgery for another lesion, the patient in Case 2 had an asymptomatic mass found on a routine chest film, and the patient in Case 1 had initially anterior chest pain as the only symptom referrable to the thorax.

Childress et al.,[5] in a review of 18 cases, reported cough as the most prominent symptom, presumably due to bronchial or tracheal pressure. Expectoration, hemoptysis, dyspnea, and pain in the chest were less frequent.

While the roentgen film may demonstrate a slightly lobulated, smoothly outlined mass, it is usually not possible to specifically distinguish lymphangiomas from other benign tumors or cysts of the mediastinum, such as duplications of the esophagus, dermoids, teratomas, bronchial cysts, pericardial coelomic cysts, or tumors of the thymus gland. However, chest x-ray will give one a clue, on occasion, as to whether a cyst or solid tumor is present by the change in shape of the cystic neoplasm on respiration (Case 2).

Treatment

Complete excision is the treatment of choice and can usually be carried out with relative ease. Occasionally neighboring vital structures will be incorporated into the wall of the cyst, in which case complete excision may be attended by an unjustified risk of injury. When this is true, marsupialization or incomplete excision may be done. If the cyst is very large, aspiration will lessen the difficulty with exposure.[26]

Gross and Hurwitt[27] reported three cases of mediastinal lymphangiomas in which one was marsupialized and two were excised. The lining of the marsupialized lymphangioma was diffusely swabbed with tincture of iodine to destroy its lining membrane. Touroff and Seley[28] reported a different sclerosing substance. They presented a 3½-year-old boy who had persistent chylothorax from a lymphangioma of the mediastinum. The tumor was partially excised and Lipiodol (5 cc.) was injected into the remaining portion. Lipiodol produced a plastic fibrinous exudate which sealed over the remaining openings into the chyle ducts after the main lymphangioma had been excised and the major channels closed by suture or ligation.

Radiotherapy, although advocated by a few for the treatment of cervical hygromas, is not recommended according to Maier[29] for lymphangioma in any area.

In all of our patients surgical excision was the treatment of choice. In some of the patients important structures, such as kidney and segments of intestine, were sacrificed to accomplish total excision of the cystic lymphangioma.

Comment

The difficulty in determining the diagnosis, the variable, nonpathognomonic clinical picture presented, its occurrence, the difference of opinion concerning the origin of this lesion, and finally the unpredictable ease or difficulty of removing this cystic tumor, all make the lymphangioma a challenging clinical problem.

Ages of the patients in this group of eight varied from 3 months to 46 years. Delay in the development of symptoms of some patients is due to the benign, slow-growing, soft, yielding nature of the lesion. Only when lymphangiomas become very large, involve neighboring structures or develop infection, hemorrhage, or rupture, do symptoms occur. Of the eight presented cases, four (50%) were asymptomatic.

One should be alert to the possible presence of this lesion and to the fact that it may occur in unusual sites such as mediastinum, perirenal area, mesentery, omentum, spleen, and retroperitoneal area. A biopsy should be taken and a frozen section done to establish the diagnosis. When the cyst involves an important structure, a proper course of action can be plotted to the end that important structures are not needlessly sacrificed. Instead, the cystic lymphangioma may be incompletely excised and the wall of the remaining lesion swabbed with a sclerosing agent, or the area may be marsupialized. These techniques have given good results.

Summary

Eight cases of cystic lymphangioma in the following unusual sites have been reported: (1) perirenal and posterior mediastinum (separate neoplasms), (2) superior mediastinum, (3) posterior mediastinum, (4) spleen, (5) mesentery, (6) retroperitoneal, and (7) greater omentum. The literature was reviewed and etiology, incidence, pathology, clinical picture and treatment were discussed.

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Factors in Automobile Accidents

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EACH YEAR in the United States almost 100,000 people are killed by accidental means. Of these more than 30,000 die from automobile accidents.[1] In its 60 years of existence the automobile has been the cause of more deaths than the total that has resulted in the armed forces in all the wars America has fought since 1776. In fact automobile accidents are the leading cause of death in the armed forces themselves. These facts are especially appalling when it is realized that accidents are the principal cause of death between ages 1 and 35. It is not until after age 35 that such things as heart disease and cancer begin to displace accidents on the list of killers. If the cancer in a 70-year-old person is cured, the patient may live another four or five years only to succumb to some other disease. However, when an 18-year-old person dies in an automobile accident, about 50 years of life have been snuffed out.

In the United States more than 5,000,000 people are injured every year by motor vehicles. The cost of these injuries, including medical and hospital expense, administrative costs, motor vehicle and property damage, and wage loss due to inability to work, is over $10,000,000,000 a year.[1,2]

In the last five years many studies of the causes of this carnage have been undertaken. The United States Public Health Service, the National Safety Council, the American Medical Association, the American College of Surgeons and other groups have shown increasing interest and activity not only in the medical but also in the nonmedical aspects of automobile accidents. Physicians have a definite community obligation both in regard to the care of those injured and in the preventive aspects.

It is known that fatigue, alcohol, emotional stress, age, physical condition, and such things as sight, hearing, speed, and weather conditions play a part in accidents.[3] Certain things in the design of vehicles, such as obstruction of vision and accessibility of controls, become important factors in accidents. The automobile industry has done several things through the years to make cars safer. Shatter-proof safety glass has been installed. In 1955 all the major companies made changes in the door locks which reduced the likelihood of doors flying open on impact. This keeps people in the automobile from being catapulted out. Accident statistics show that death is five times more likely if one is thrown from a car.[4] Probably the biggest safety fault in American automobiles today is the brake. When the brakes are applied at higher speeds, deceleration falls off rapidly. This is because the friction surface provided on the drum is too small and cooling is inadequate. Brake "fade" is due to a small, overheated brake.

The paucity of injuries among stunt and stock car drivers is impressive. These men walk away unscathed from spectacular accidents involving standard automobiles. There are just three inovations which protect these men: crash helmets, roll-over bars, and seat belts.

The application of the crash helmet is obvious. Seventy-two per cent of injuries sustained in automobile accidents are head injuries.[5] Head injuries are the cause of more than half of the fatalities. The roll-over bar is a reinforcing steel support which prevents crushing of the roof of the vehicle. The current style emphasis on the hard-top convertible with little roof support increases the likelihood of crushing.

The real danger in an automobile accident is not the impact itself. The injuries are sustained by the body being thrown out of the car or striking the interior of the car. The occupants in a car in an accident are much like dice in a shaker. If the dice are anchored to the inside of the shaker, there is no mixing and striking of the interior. The same is true with the automobile. If the occupants are anchored to the frame of the automobile, they do not bounce around and strike the windshield, the steering wheel, dashboard, or the roof.

Presented at 1960 fall meeting of the Wisconsin Surgical Society.

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By reviewing accidents involving 300 cars equipped with seat belts and over 4,000 other cases of accidents in which seat belts were not used, Braunstein, Moore, and Wade[6] at Cornell were able to match very closely 81 cars without seat belts with 81 cars with seat belts. These control and experimental groups of cars were identical as to type of accident, area of principal impact, direction of principal force, speed at impact, frequency of doors opening, number of cars per accident, make of case car, weight of case car, year of manufacture of car, and seated area of occupants. It was vividly proved that where seat belts were in use the severity and number of injuries were reduced by 60%. Other studies have supported this conclusion.

The value of seat belts is no longer an academic question. The Cornell Studies have shown that of the 30,000 lives lost each year in motor vehicles, 5,500 could be saved by the use of seat belts. The American Medical Association, the U. S. Public Health Service, and the National Safety Council are solidly behind a national campaign to popularize the use of seat belts in passenger cars. Former Secretary of Health, Education and Welfare Arthur S. Flemming while in office ordered safety belts installed in all departmental vehicles. Legislation (H.R. 1341) is before Congress which would make belts mandatory in every Federal vehicle. In the State of New York a law is pending which would make seat belts mandatory in all new cars sold in New York after July 1, 1961. Through business and professional groups physicians should conduct coordinated seat belt campaigns in their communities. Drivers should be urged to purchase only belts that are manufactured and installed in accordance with the recommendations of The Society of Automotive Engineers.

The Hampton Report[7] showed that in many cities across the country there are serious deficiencies in the immediate care of the injured. Proper equipping and regulation of ambulance and police emergency vehicles and adequate first aid instruction for police, firemen, ambulance operators and attendants are absolutely necessary. Rough and inept handling of the injured can in some cases cause more harm and disability than the original trauma itself.

The speed of emergency vehicles should also be regulated. Curry[8,9] has shown that in 2,500 consecutive ambulance runs, an average speed of over 30 miles per hour would not have beneficially influenced the course of a single injury. The danger to the patient, to the ambulance operators, and to other drivers and pedestrians at excessive ambulance speeds far outweighs the improbable advantage of an earlier arrival at the hospital.

The problem of tetanus immunization confronts every physician whose patient receives an open wound in an automobile accident. The inadequacies and dangers of passive immunization with tetanus antitoxin are manifest because the only major segments of our population actively immunized with tetanus toxoid are those under 15 years of age and those who have been in the armed services. It is the considered opinion of the Subcommittee on Prophylaxis Against Tetanus of the Committee on Trauma of the American College of Surgeons that "1,500 units of tetanus antitoxin are of limited and transitory value and are inadequate dosage; if tetanus antitoxin is really indicated, the dosage should be a minimum of 5,000 units. Tetanus can develop even with passive immunity particularly after the first week." The point is also made that the patient sensitive to horse serum is likely to neutralize it very rapidly. The Committee urges that in the case of the unimmunized patient with a clean, minor wound in which the decision is made not to give tetanus antitoxin, the opportunity to start tetanus toxoid immunization should not be wasted. Also, in patients who are given tetanus antitoxin, active immunization with tetanus toxoid with a separate needle and syringe in the opposite extremity should be started at once and continued to completion. The mortality from tetanus, once contracted, is still about 50%. Legislation has been presented in the State of New York which would make it mandatory for every citizen renewing a driver's license to show proof from his physician that he has completed a series of tetanus toxoid immunizations.

The fact that every year more than 4,000,000 Americans require physicians' services because of injuries sustained in automobile accidents presents a challenge and opportunity in the field of preventive medicine.

The Sheboygan Clinic

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DIRECT CLOSURE OF INTERATRIAL SEPTAL DEFECTS

Lyle Jacobson, M.D., Prescott Jordan, Jr., M.D., and Vollrad Von Berg, M.D., Receiving Hospital, Detroit. Abstract from *Journal of the Michigan State Medical Society*. 59:1712 (Nov.) 1960.

The last eighteen months' experience with direct closure of interatrial septal defects is reviewed. Forty-one patients were operated upon a total of forty-four times. Thirty-nine had secundum defects, and of these, three were associated with anomalous venous drainage. Two patients with septum primum defects were also operated upon. Hypothermia and cardiopulmonary bypass were each used twenty-two times as the means of obtaining a dry heart. The advantages, as well as the disadvantages, of these two methods are discussed in some detail. The criteria for selecting each method are emphasized.

The important features contributing to the success of hypothermia are enumerated, and they include a narrow temperature range of 31–32° C., a short occlusion time of four to five minutes, the maintenance of respiratory alkalosis, the avoidance of air embolism, and the avoidance of patients with pulmonary hypertension.

There were forty survivals and four deaths in this series. The deaths were confined to the cardiopulmonary bypass group, and this is undoubtedly related to the more advanced and complicated lesion operated upon by this method.

The factors contributing to mortality are discussed in general and as they are related to our four deaths. These factors included the complexity of the lesion, pulmonary hypertension, arrhythmias, the stage of the disease, and previous surgery.

The favorable nature of this lesion and the desirability of early closure are emphasized.

THE COMBINED TREATMENT OF CARCINOMA OF THE CERVIX WITH FULL IRRADIATION THERAPY FOLLOWED BY RADICAL PELVIC SURGERY

Robert R. Turner, M.D., Department of Obstetrics and Gynecology, Wayne State University College of Medicine, and Department of Gynecology, Detroit Receiving Hospital. Abstract from *Journal of the Michigan State Medical Society* 59:1564 (Oct.) 1960.

Our study of the combined treatment for carcinoma of the cervix commenced in 1949 and is being made in an effort to evaluate its effectiveness as a treatment method and to ascertain its place, if any, in the over-all treatment of the disease.

A series of ninety-four cases of carcinoma of the cervix treated first with full irradiation therapy, followed in from four to fifty-two weeks after its completion with radical Wertheim operation, is presented.

The operative mortality in the series is zero. The over-all vaginal fistuli rate is 14 per cent. The incidence of ureterovaginal fistula is 5 per cent; of vesicovaginal fistula, 2 per cent; of rectovaginal fistula 4 per cent; and of combined vesicovaginal and rectovaginal fistulae, 4 per cent. Fistulate closed spontaneously in four women and were cured in four women by operation. Closure did not occur in the remaining six women, and four of them have died, three from recurrence of their malignancy.

Of the ninety-four patients, fourteen died; eight from recurrence of disease, and six of other diseases but with no evidence of recurrence of cancer at the time of death.

Residual carcinoma was found in the surgical specimens from twenty-six of the ninety-four women. Six of these have died, five from recurrence, giving a corrected survival rate of 80 per cent in the "residual group."

Sixty-eight women had no detectable residual cancer in their specimens. Three of these died from recurrence of their disease, thus giving a corrected survival rate of 95 per cent for the "non-residual group."

Carcinoma was found in pelvic lymph nodes in seven of the ninety-four patients, an incidence of 8 per cent. This is one third the incidence usually found in treatment by surgery alone. We conclude that adequate deep therapy eradicates pelvic nodal cancer in two thirds of the patients.

Our fistula rate of 14 per cent is still too high, but by decreasing radium dosage and modifying surgical technique, we are confident we shall be able to reduce it to a more respectable level.

It seems at this time that combined therapy may prove an adequate method in treatment of Stage I, II, and early Stage III carcinoma of the cervix, but final evaluation must wait further follow-up observations.

Clinical Studies With a New Corticosteroid, 6-Alpha-Fluoro-Prednisolone (Fluprednisolone); A Preliminary Report

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CHEMICAL modification of the prednisteroid nucleus in an effort to enhance anti-inflammatory and antiallergic potency while decreasing side-effects has resulted in several clinically improved corticosteroids.

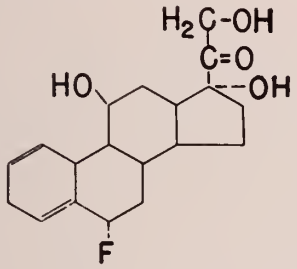

Fig. 1—Chemical structure of 6-fluoro-prednisolone (U—7800).

The introduction of fluorine at C_9, or a methyl radical at C_2, C_6 or C_{16} has augmented the glucocorticoid activity and resulted in clinically useful steroids. In 1958 clinical supplies of a new synthetic corticoid, U-7800, became available. This compound is the 6-alpha-fluoro derivative of prednisolone (Fig. 1) and is called fluprednisolone. Laboratory animal data indicate that it is 80 times more potent than hydrocortisone by the glycogen deposition assay, and 8 times more potent than hydrocortisone by the granuloma pouch assay.[1] Since there has been no previous clinical report regarding this new steroid, it was deemed worthwhile to cite our preliminary experience with this drug. The object of this study was to answer the following questions: Has fluprednisolone anti-inflammatory and antiallergic properties in man? What is its relative glucocorticoid potency? Does it possess any unique side-effects?

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Materials and Methods

Clinical experience extends over a 17-month period and consists of administering fluprednisolone to 72 patients with a variety of illnesses for which steroids were felt to be indicated. Patients were followed at the University of Wisconsin Hospitals, the University of Wisconsin Student Health Department, the Madison (Wisconsin) Veterans Administration Hospital, and the Mahorner Clinic (New Orleans, La.). Two types of clinical studies were conducted; the eosinopenic-hyperglycemic assay and therapeutic administration of this steroid to 72 subjects. The diseases being treated were as follows: systemic lupus erythematosus, 12; rheumatoid arthritis, 19; serum sickness (including penicillin reactions), 9; asthma, 5; angioedema, 4; refractory ascites, 2; chronic ulcerative colitis, 3; thyroiditis, 3; Addison's disease, 1; hypoplastic anemia, 1; hemolytic anemia, 4; nontropical sprue, 1; poison ivy, 4; overwhelming infections, 4. Total dosages varied from 1 to 20 mg. per day. The maximal duration of treatment of a single patient with fluprednisolone was 310 days. Twenty-eight of these patients had previously been receiving various corticoids prior to fluprednisolone. These subjects provided the best opportunity of comparing the relative potency of the steroids. Treatment of all 72 patients with fluprednisolone enabled us to observe clinical responses as well as side-effects of this new drug. Occasionally it was possible to stabilize the patient on a given dose of his previous corticoid and then change back and forth to fluprednisolone while maintaining the same clinical remission. Although highly desirable in this type of study, it is often not possible because of intrinsic variations in these diseases, as well

TABLE 1—*Results of Eosinopenic-Hyperglycemic Potency Assay*

Patient	Monday	Tuesday	Wed.	Thursday	Fri.	Sat.	Sun.	Monday	Tuesday
F. D.	Control *Eos. —287 **FBS.—105	Hydrocortisone 62 135	------	Dexamethasone Eos. — 16 FBS.—167	------	------	------	Control Eos. —250 FBS.	Fluprednisolone 31 120
R. H.	Control Eos. —287 FBS.—107	Dexamethasone 19 135	------	Fluprednisolone Eos. — 31 FBS.—130	------	------	------	Control Eos. —413 FBS.— 97	Hydrocortisone 81 117
J. R.	Control Eos. —287 FBS.—105	Fluprednisolone 56 110	------	Hydrocortisone Eos. —118 FBS.—117	------	------	------	Control Eos. —343 FBS.— 97	Dexamethasone 44 107
C. G.	Control Eos. FBS.—115	Hydrocortisone --- 128	------	Dexamethasone Eos. — 63 FBS.—135	------	------	------	Control Eos. —263 FBS.—107	Fluprednisolone 39 115
J. E.	Control Eos. —212 FBS.—107	Dexamethasone 31 115	------	Fluprednisolone Eos. — 25 FBS.—125	------	------	------	Control Eos. —213 FBS.—100	Hydrocortisone 19 115

*Eos. = eosinophil count.
**FBS. = Fasting Blood Sugar.

TABLE 2—*Results of the t-test*

Level	Drug	t-value	Probability
Eosinophils	Hydrocortisone	7.1	0.01
Eosinophils	Dexamethasone	10.8	0.001
Eosinophils	Fluprednisolone	20.2	0.0001
Blood Sugar	Hydrocortisone	9.4	0.001
Blood Sugar	Dexamethasone	2.6	0.06
Blood Sugar	Fluprednisolone	4.2	0.02

as the relative paucity of objective criteria in substituting one corticoid for another in the treatment of such diseases as systemic lupus erythematosus and rheumatoid arthritis when they are already suppressed by the previous corticoid therapy. Of course, whenever possible, fever, sedimentation rate, and American Rheumatism Association graded responses were utilized. Representative case histories are included.

The relative eosinopenic and hyperglycemic potency of fluprednisolone was determined by the method described by West.[2] Five normal subjects were employed. Three steroids were used: hydrocortisone (40 mg.); fluprednisolone (6 mg.); and dexamethasone (3 mg.). The drugs were given as a single dose at midnight. Fasting blood sugar levels were obtained at 8:00 a.m. together with total eosinophil counts. Blood glucose was determined by the Folin–Wu method, and eosinophil counts were performed in triplicate by conventional technique. Each subject served as his own control, and each patient received all three of the drugs after a 24-to-72-hour time interval between doses. Statistical analyses are included. Through the courtesy of Dr. Kelly M. West, his own independent data obtained at the University of Oklahoma School of Medicine are included in this paper. In his study, Doctor West compared the potencies of 10 mg. of prednisolone, 5 mg. of fluprednisolone, and 20 mg. of prednisolone.

Results of Eosinopenic–Hyperglycemic Potency Assay

The results of our eosinopenic-hyperglycemic assay are shown in Table 1. The test employed to determine statistical significance was the t-test, where "t" is the ratio of the difference between two means to the standard deviation of the difference.[3] Table 2 shows these results. All changes are statistically significant and predictable with the exception of the blood sugar value when dexamethasone was administered. A very definite trend is established here, however. From the degree of induced eosinopenia, fluprednisolone is 12.0 times more potent than hydrocortisone. From the degree of hyperglycemia, it is 7.0 times more potent than hydrocortisone. Doctor West's data are given in Table 3. Note that 20 mg. of prednisolone produced in each of five subjects higher blood glucose levels than did 5 mg. doses of fluprednisolone. Furthermore, the eosinopenic responses of each of these subjects were greater after this dose of prednisolone. On the other hand, when 10 mg. doses of prednisolone were administered to these same subjects, the eosinopenic and hyperglycemic responses were very slightly greater after 5 mg. of fluprednisolone (difference is not statistically significant). From these data it appears that fluprednisolone is about two to three times more potent per milligram than prednisolone. Previous experiences have shown that prednisolone is about four times more potent than hydrocortisone, so that these data suggest

TABLE 3—*Comparison of Potencies of Prednisolone and Fluprednisolone*

Subject	Age	Sex	5 mg. Fluprednisolone		10 mg. Prednisolone		Control		20 mg. Prednisolone	
			Glucose	Eosin.	Glucose	Eosin.	Glucose	Eosin.	Glucose	Eosin.
1. ALR	26	F	92	28	85	33	80	230	96	2
2. RJM	26	F	70	99	82	12	67	296	117	13
3. TEC	27	M	83	30	80	53	73	143	92	14
4. RJW	24	M	77	10	73	21	67	71		
5. OLE	24	M	82	245	87	306	75	520	96	134
6. JK	27	M	85	63	73	111	67	266		
7. PRO	25	M	71	56	70	58	65	286	90	11
Means			80.0	75.9	78.6	84.9	70.6	258.9	98.2	34.8

that fluprednisolone is approximately 8 to 12 times more potent than hydrocortisone on a milligram basis. The excellent correlation between the data we obtained at the Madison Veterans Administration Hospital and Doctor West's results at the University of Oklahoma seems to us to lend credence to his method as being a simple and valid one for the rapid estimation of glucocorticoid potency of new steroids.

Results of Therapeutic Administration

Fluprednisolone has proved to be a potent glucocorticoid. Like the currently available other prednisteroids, its initial use will generally produce dramatic and rapid suppression of the signs and symptoms of serum sickness, thyroiditis, asthma, angioneurotic edema, rheumatoid arthritis, ulcerative colitis, lupus erythematosus, and many other diseases. In general, the dose necessary for the treatment of these illnesses is one-half to one-third that of prednisone or prednisolone. Table 4 shows the doses of fluprednisolone which achieved equivalent control of the disease in 16 patients previously maintained on other corticosteroids. Assigning precise numerical values or potency numbers to these steroids on the basis of such results is precarious, but certainly an over-all general estimate of the relative potency of fluprednisolone on a milligram basis can be deduced. From the data in Table 4, and from the treatment of all 72 patients in this study, it is felt that fluprednisolone is approximately 10 times more potent than hydrocortisone, or 2.5 times more potent than prednisolone.

Side-Effects

The side-effects noted in this study were not severe and in no instance was it necessary to withdraw the drug. A Cushingoid type of central obesity with moon-face, supraclavicular and cervical fat pads were generally noted in patients whose doses exceeded 6 mg. per day for two months or longer. Purpura occurred in one patient receiving 12 mg. per day for seven days. Hypertension was conspicuously absent from this study and pre-existing hypertension did not seem to be aggravated by prolonged administration of this steroid. Indeed, the patient who received the largest daily dose (20 mg./day) remained somewhat hypotensive throughout her course (see Case 1 below). Since the plasma sodium levels of dogs treated with 3 mg. per kg. per day of fluprednisolone were somewhat reduced after 14 days,[1] the possibility of inducing hyponatremia or other electrolyte alterations was particularly studied in patients receiving the higher doses. Although in one patient a dose of 18 mg. per day for seven days failed to produce any changes in serum sodium, potassium, chloride or carbon dioxide combining-power, another patient receiving 20 mg. per day for 30 days did have hyponatremia (118 mEq./l.) as described below

TABLE 4—*Results of Control of Disease with Fluprednisolone in Patients Previously Maintained on Other Corticosteroids*

Patient No.	Disease	Previous Corticoid Therapy		Doses of Fluprednisolone for Equivalent Control (mg./day)
		Drug	Dose (mg./day)	
1	S.L.E.	prednisolone	15.0	6.0
2	S.L.E.	prednisolone	10.0	3.0
3	S.L.E.	prednisolone	15.0	3.0
4	R.A.	prednisolone	15.0	6.0
5	Sprue (N.T.)	prednisolone	30.0	12.0
6	S.L.E.	prednisone	20.0	8.5
7	C.U.C.	prednisone	10.0	4.0
8	S.L.E.	triamcinolone	12.0	5.0
9	R.A.	triamcinolone	12.0	4.0
10	R.A.	methylprednisolone	16.0	7.5
11	R.A.	methylprednisolone	6.0	3.0
12	R.A.	methylprednisolone	8.0	4.5
13	Asthma	methylprednisolone	8.0	6.0
14	Asthma	dexamethasone	2.0	4.0
15	S.S.	dexamethasone	3.0	5.0
16	Addison's	hydrocortisone	25.0	2.25

S.L.E.—systemic lupus erythematosus.
R.A.—rheumatoid arthritis.
C.U.C.—chronic ulcerative colitis.
S.S.—serum sickness.
N.T.—nontropical sprue.

in Case 1. This case is complicated by the co-administration of 750 mg. per day of chlorothiazide for the edema she developed. Only one other subject developed edema in this series. This was an elderly man with hypoplastic anemia receiving 12 mg. per day for a six-week period. No peptic ulcers were detected and in no instance did gastrointestinal intolerance develop. Routine roentgenographic studies were not performed, however. No known diabetic subjects were included in this study. Steroid diabetes occurred in one patient receiving dexamethasone and persisted on fluprednisolone (see Case 5). Little effect on appetite or body weight could be attributed to fluprednisolone. The two subjects who developed transient but controllable edema also sustained progressive weight loss, but their primary disease states (metastatic breast carcinoma and idiopathic hypoplastic anemia) were considered to be the more likely cause.

Case Reports

Case 1. A 41-year-old woman had undergone a left radical breast mastectomy followed by x-ray therapy in July, 1958, for a highly anaplastic breast carcinoma. Axillary nodes contained metastatic carcinoma. An ovariectomy was done in December, 1958, and a bilateral adrenalectomy performed in July, 1959, because of widespread metastases and sufficient pain to require constant use of narcotics. Postoperatively she did well on a maintenance of 9-alpha-fluoro-hydrocortisone (0.1 mg./day) and hydrocortisone (30 mg./day) and was able to return to work free of pain. For academic reasons the hydrocortisone was replaced with fluprednisolone (0.75 mg. every eight hours) for a four-week interval with no apparent ill-effects. Of course, the 9-alpha-fluoro-hydrocortisone (0.1 mg./day) was maintained. Total eosinophil count, fasting blood sugar, and serum electrolytes remained essentially unchanged.

Four months later she began to deteriorate rapidly with cerebral, dermal and skeletal metastases. Large doses of androgens, fluprednisolone (20 mg./day) and triiodothyronine were begun. This regimen was of little benefit, and in January, 1960, she was virtually terminal. The side-effects of this dose of fluprednisolone are of particular interest because this was the largest dose administered in this series. She developed a classical Cushingoid appearance—central obesity, thin extremities, moonface, dorsal and supraclavicular fat pads, abdominal striae, and plethora. Her blood pressure remained normal throughout (range from 100/60 to 130/80). Although she developed periodic pedal edema (which responded to chlorothiazide), methyltestosterone (20 mg./day) probably contributed to the edema. Two months after receiving this dose of fluprednisolone, the serum sodium level fell to 118 mEq./1, while other electrolytes remained normal. Prior to this she took three of her "edema pills" (total of 750 mg./day of chlorothiazide) on her own initiative because she felt she needed them to void. It is very possible that corticoid was a factor in her hyponatremia. She also complained of weakness and leg cramps, but her underlying disease and other medications made the incrimination of a single drug precarious, though worthy of further scrutiny.

Case 2. A 34-year-old man received tetanus antitoxin (5,000 u.) subsequent to a leg injury. Within 24 hours he had a severe serum sickness reaction with giant pruritic urticaria, generalized edema, fever, and erythema of the palms and face. He was given 1 mg. of fluprednisolone every six hours. After his second dose his symptoms completely disappeared and when seen the following day he had no signs of the serum reaction. His drug was continued at this same dose for three days, then discontinued without ill-effect.

Case 3. A 24-year-old man received 1.2 million units of benzathine penicillin for beta-hemolytic streptococcal pharyngitis. Within 48 hours he had severe polyarthritis, generalized myalgia, and urticaria. This patient had a bleeding duodenal ulcer six months before. He failed to respond to antihistaminics, ephedrine, salicylates, and penicillinase (800,000 units per day for three days). He was placed on fluprednisolone, 2 mg. every eight hours, and his symptoms subsided over a 48-hour period. The dose was then reduced to 1 mg. every eight hours for 14 days, and then completely withdrawn. He had no side-effects but was placed on a prophylactic ulcer regimen, including bland diet, antacids, and anticholingeric drugs, at the outset of corticoid therapy.

Case 4. This 35-year-old woman had rheumatoid arthritis of four years' duration, manifested chiefly by crippling lesions in the proximal interphalangeal joints of both hands, but also with arthritis of the shoulders and wrists. She had previously been maintained on 5 mg. of prednisolone at eight-hour intervals for eight months' duration, and before this, she had been given prednisone and hydrocortisone over a 26-month period. She was also taking 6 gm. of aspirin daily. Her symptoms were always worse in the morning, and she had no serious side-effects from her previous steroid therapy, except for a rounded-face and supraclavicular fat pads. Two milligrams of fluprednisolone every eight hours were successfully substituted for the 5 mg. doses of prednisolone she had previously been taking, with equivalent suppression of her symptoms. She is the mother of four children, and able to carry on her daily chores with minimal symptoms (chiefly early morning stiffness in the joints involved) on either 2 mg. of fluprednisolone or 5 mg. of prednisolone three times daily together with 6 gm. of salicylates.

Case 5. A 38-year-old woman with the diagnosis of systemic lupus erythematosus of eight months' duration, manifested in the past by elevated sedimentation rate, positive LE cell preparations, fever, polyarthritis, and albuminuria, was first seen because of a unilateral pleural effusion with dyspnea. After initial thoracentesis, she was treated with dexamethasone, 0.75 mg. every eight hours, with only minimal improvement. The dose was increased to 3.0 mg. every eight hours with an excellent remission. The LE cell preparation remained positive and the sedimentation rate was still elevated (32 mm./hr.) After one week's observation, she was released from

the hospital on 1.5 mg. dexamethasone every eight hours and seemed to do satisfactorily. Five weeks later on a routine outpatient visit her fasting blood sugar was 245 mg. % and a + + + + glycosuria (without acetonuria) was noted. Prior to steroid therapy her fasting blood sugar had been 118 mg. %. She gave no history of familial diabetes. Dexamethasone was reduced to 0.75 mg. every eight hours but the blood sugar remained elevated at 272 mg.%. She was given regular insulin on a "sliding scale" and the diabetes regulated. She was changed to fluprednisolone, 2.0 mg. every eight hours, and her insulin requirements remained the same. She was then slowly withdrawn from all steroids but developed severe joint and chest pain, fever to 104 F. (40 C.), albuminuria, and "butterfly" face rash. Fluprednisolone was reinstituted at 1.0 mg. every six hours along with 25 units of NPH insulin daily, and she has done satisfactorily without need to increase her insulin requirements. No other side-effects to treatment with fluprednisolone were noted after five months' observation at this dose level.

Case 6. A 33-year-old woman with nontropical sprue of two years' duration had been initially treated with prednisolone (10 mg. three times daily), folic acid, B_{12}, calcium and multi-vitamins with a good response. She was then maintained on 15 mg. per day for 21 months, and she did satisfactorily maintaining a maximal weight of 88 lb. She was first seen in May, 1959, with an exacerbation of steatorrhea and weighing 78 lb. At this time she demonstrated impaired fat, xylose and vitamin A absorption, as well as the cosmetic side-effects of her previous steroid treatment—mild acne and hypertrichosis, moon-face, and dorsal fat pads. Two weeks earlier she had increased her dose of prednisolone to 10 mg. three times daily without significant improvement. She was placed on a gluten-free diet together with 30 mg. per day of prednisolone and her previous vitamin and mineral supplements, and slowly improved over a three-month interval. She was changed to fluprednisolone, 4 mg. every eight hours, along with the gluten-free diet and other supplements, and was able to maintain an equivalent degree of clinical remission. Attempts to reduce her dose of steroid have been unsuccessful. She has developed no untoward side-effects after 125 days treatment with this steroid, although her Cushingoid appearance has persisted.

Comment

Ideal corticosteroids for replacement therapy in primary or secondary adrenocortical insufficiency are available in the form of glucocorticoid (hydrocortisone) and mineralocorticoid (either desoxycorticosterone or 9-alpha-fluorohydrocortisone). But the vast field of clinical application of corticoids is in *suppressive* rather than *replacement* treatment, and no ideal corticosteroid yet exists in this realm. Perhaps it is impossible to produce a steroid which acts only peripherally, which will possess potent anti-inflammatory and antiallergic action without antianabolic, ulcerogenic, diabetogenic or similar adverse effects. Nevertheless, continued modification of the corticoid nucleus is being undertaken in the hope of enhancing specific biologic activity.

We have found fluprednisolone to be a potent new anti-inflammatory and antiallergic corticosteroid. Utilizing both the hypoglycemic-eosinopenic assay technique and clinical treatment of both acute and chronic cases, this drug has often dramatically suppressed symptoms and signs of the disease. Doubtless, other corticoids in appropriate doses would have achieved similar beneficial effects. But with fluprednisolone it is possible to employ smaller doses than would be needed with most of the currently popular steroids. That fewer milligrams are consumed is not in itself an advantage, but if fewer side-effects are thereby produced, this is a significant advantage. It has been our experience that an occasional patient, although initially responsive to a given corticoid, may later become relatively resistant to that particular drug. Since increasing the dose would also increase the hazards of steroid side-effects, we prefer to change such patients to another steroid at equipotent doses, preferably one without any unique side-effects, and fluprednisolone appears to be such a drug. Our data indicate that fluprednisolone is approximately 2.5 times more potent on a milligram basis than prednisolone. The side-effects noted were minimal and virtually nonexistent with small doses. However, with large doses (6 mg./day or more) typical "cosmetic" (Class I)[4] side-effects were noted. Although toxicity was not severe enough to require withdrawing the drug in any patient in this series, more experience is needed to fully evaluate the effects of large doses.

Summary

A new corticosteroid, fluprednisolone, has been administered to 72 patients with a variety of illnesses for which corticoids were felt to be indicated. Fluprednisolone has proved to be a potent anti-inflammatory and antiallergic steroid. Hyperglycemic-eosinopenic assay in man has shown fluprednisolone to be approximately 10 times more potent than hydrocortisone, or 2.5 times more potent than prednisolone on a milligram basis. Side-effects have been minimal, and generally those characteristic of the newer prednisteroids. Although the results of the preliminary study have been encouraging, further

experience with this drug will be necessary before any definite conclusions can be formed as to its therapeutic advantages.

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The fluprednisolone employed in this study was generously supplied by Dr. Hubert C. Peltier of The Upjohn Company, Kalamazoo, Michigan, and has the trade name Alphadrol.

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Dressing Burns Without Opiates

By HUGH A. JOHNSON, M.D., M.S.

Rockford, Illinois

A PAINLESS method of changing dressings on severely burned patients is of benefit to the patient and appreciated by the hospital personnel as well as the attending physician. It makes the use of opiates unnecessary and thus avoids their disagreeable and harmful effects.

The method I have devised consists of immersion of the patient, no matter how severely burned, in normal saline solution at body temperature. This can be accomplished under sterile conditions by using the following technique:

The physiotherapy room is usually the most convenient place to work. All personnel are masked and wear rubber gloves. The tub is cleaned with full strength Lysol with a cellulose sponge and rinsed with tap water. Water at body temperature is added to a level necessary to cover the patient. Salt from a previouly unopened container is added to produce a normal saline solution. Calibration of the tub in liters facilitates determination of the proper amount of salt to add. About half a cup of detergent (Pink Dreft for children) is added to cut the greasy skin secretions when the full body bath is used. The patient is then brought into the room. The outer dressings are cut and laid carefully aside. The patient is then picked up by the gloved physician and physiotherapist and placed in the sterile saline bath. While the physiotherapist goes through the indicated exercises, most of the dressings drift off. The patient can be kept comfortable for hours if the temperature of the water is maintained at the optimum level. In the meantime, the physician spreads a sterile sheet over a cart and lays out the back dressings if the burns are circumferential. The J–D packs made by Johnson & Johnson, fine mesh Furacin gauze, and the Conform and Kling bandages I find most useful.

With the use of this technique I have found that the healing time is considerably reduced, the number of complications lessened, and the nutritional state of the patient is maintained at a better level.

2500 North Rockton Avenue.

Cancer Chemotherapy of Solid Carcinoma

By JOHN D. HURLEY, M. D., and JOHN RIESCH, M. D.

Milwaukee, Wisconsin

RECENT widespread interest and enthusiasm for the use of antitumor chemotherapy has prompted this review of our experience over the past four years at our hospital. Five hundred patients treated with a variety of antitumor agents will be discussed relative to the agents used, response to treatment and toxicity of the drugs. Of the 500 patients treated, 167, or 1 in 3, have been improved by the antitumor agent or agents used.

Our criteria for improvement have been those aptly described by Ansfield and Curreri.[1] These have included a measurable reduction in tumor size; symptomatic improvement as measured by a decreased narcotic need, for example; improvement in the performance status and a leveling off or reversal of the downward weight curve; and of most significance, a maintenance of all of the above for a minimum of two months.

In this group of 500 patients, a variety of antitumor agents has been utilized. These have included the two main groups of agents in popular use today; the alkylating agents, and the antimetabolic agents. Of the alkylating agents, nitrogen mustard, triethylenemelamine and triethylenethiophosphoramide have been used most frequently. Of the antimetabolic agents, methotrexate, 6-mercaptopurine and 5-fluorouracil have been used extensively. Our dosage schedules have been varied and tend to vary from period to period depending upon the enthusiasm and the vigor with which we have studied any particular agent. At the present time, however, our standard dosage schedule for nitrogen mustard (HN_2) is 0.6 to 0.8 mg. per kg. of body weight given in divided doses and repeated at two-month intervals as long as the patient responds to therapy. Our present dosage schedule with triethylenemelamine (TEM) is 10 mg. per day in a single dose administered either orally or intramuscularly over a four-to-six-day period until a total dosage of 40 to 60 mg. has been given; then the treatment is repeated each six to eight weeks. The dosage schedule with triethylenethiophosphoramide (TSPA) is 0.8 to 1.2 mg. per kg. of body weight given in divided doses either intravenously or intramuscularly over a four-or-five-day period and followed in two weeks by a weekly maintenance dose of 0.4 mg. per kg. of body weight until the patient fails to respond. With these dosage schedules toxicity, as will be explained later, tends to be quite frequent. The antimetabolic agents have been used in similar large doses with frequent repetition of the dosage schedule. Methotrexate (MTX) has been used at the level suggested for the treatment of choriocarcinoma by Hertz at the National Cancer Institute. The standard course consists of 15 to 25 mg. per day for a four-to-five-day period until a total dosage of 75 to 100 mg. has been given. These dosage regimens are then repeated at six-week intervals. 6-mercaptopurine (6-MP) is given in dosages of 200 to 400 mg. per day for periods of 5 to 10 days with total dosage of 1 to 4 gm. and the course of therapy is then repeated at monthly intervals. 5-fluorouracil (5-FU) schedules have been those outlined by Ansfield and Curreri.[1]

Toxicity with these agents at the above outlined dosage schedules is quite high. Combinations of alkylating agents, alkylating plus antimetabolic agents, and antimetabolic agents have been tried empirically in an effort to extend palliation for certain tumor areas and to prolong the useful palliation in other areas treated with single drugs. The numbers of different combinations are difficult to outline in a short review such as this.

Response to therapy has included a number of tumor areas (Fig. 1). Breast carci-

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Presented at the annual meeting of the State Medical Society of Wisconsin, May 5, 1960, Milwaukee.

From the Department of Surgery, Milwaukee County Hospital and Marquette University School of Medicine.

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Doctor Riesch is a Resident in Surgery, Milwaukee County Hospital.

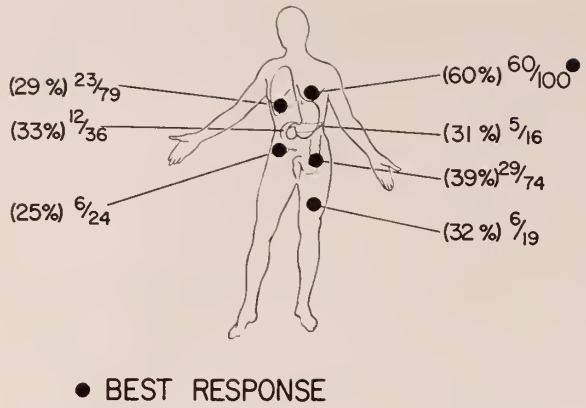

Fig. 1—Responsive tumors; chemotherapy end results.

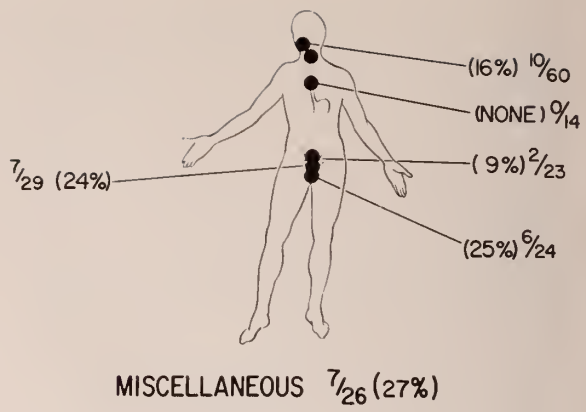

Fig. 2—Nonresponsive tumors; chemotherapy end results.

noma has been the most responsive with 60 out of 100 patients treated responding, utilizing the criteria mentioned above. Colon and rectal carcinomas have been benefited in 39% of the cases (29 out of 74). Gastric carcinomas were responsive in 33% of the patients treated (12 of 36). Soft tissue sarcomas responded in 32% of the cases treated (6 out of 19). Pancreatic carcinoma was benefited in 31% of the patients treated (5 of 16). Of the patients who were treated for bronchogenic carcinoma 29% were benefited (23 of 79). In 6 of 24 patients treated for ovarian carcinoma 25% were benefited. Response in many of these areas has been gratifying and has extended long past the two-month period listed as the minimum for the tumor response to an antitumor agent. In some of these areas the response has been dramatic with a single drug, such as the pancreas or colon when treated with 5-fluorouracil. In other areas response was most marked with drug combinations such as in the sarcomas and gastric tumors treated with combinations of alkylating and antimetabolic agents. Newer antitumor agents have been recently tested in some of the tumor areas and have improved the tumor response even beyond those cited above.

More experience with drug combinations is essential, in our experience, to determine the maximum efficiency and utilization of these antitumor agents. We have the feeling that response is a function not only of the antitumor agent used but also of the general status of the patient before, during and after treatment with antitumor therapy. For the most part, these patients should be prepared for antitumor therapy just as one might prepare a patient for a major operative procedure.[2-5] It has been demonstrated by Wolberg and Curreri[6] that the toxicity of some of the antitumor drugs, particularly 5-fluorouracil, is increased in patients who are protein depleted; and since this is a common denominator in patients who are somewhat wasted and debilitated from any extensive widespread carcinoma, toxicity could be anticipated in a high percentage of our patients.

Some of the tumor areas have been most unresponsive or poorly responsive to antitumor therapy (Fig. 2). Head and neck tumors in general, with 60 cases treated, have been relatively unresponsive to therapy. Only 10, or 16%, of this group have responded at all to any of the agents or combinations used in an attempt at palliation.

Pelvic carcinomas, including carcinomas of the uterus, cervix, bladder and prostate, have also been unresponsive to therapy. In this group there were 52 patients with 9 responding to therapy. We also have treated 14 patients for tumors in the esophagus without a demonstrable beneficial response to single agents or combinations of antitumor agents. In these areas newer drugs are being used, different combinations of drugs are being tried, as well as newer approaches to therapy, such as the attempts at regional perfusion for head and neck and pelvic tumors. These approaches and these techniques, we hope, will extend our ability to palliate and to manage patients with inoperable or incurable tumors in these areas.

Toxicity with these agents in the dosage schedules outlined can be a serious problem, both for the treating physician and the patient undergoing therapy. Toxicity, we feel, is the sought-for therapeutic endpoint, but

the toxic side-effects must be understood, anticipated and vigorously treated when they occur. The lesser toxic complications, such as nausea, vomiting and diarrhea, tend to be more easily managed and less troublesome to the physician treating the patient, although of some major concern to the patient during the course of therapy.

Severe leukopenias do occur and death can occur as a result of the undue or unsuspected sensitivity of the patient's bone marrow to the antitumor agent used. The leukopenias when they occur require careful protection of the patient and vigorous antibiotic therapy for intercurrent infections when pressent, in order to prevent undue morbidity and mortality until the leukocyte count returns to normal levels.

In our hospital it has been the policy to treat patients with leukocyte counts below 2,000 by placing them in isolation and starting antibiotic therapy promptly for any febrile episode that might occur whether the cause has been diagnosed or not.

The toxicity will be described and discussed separately for each of the treatment schedules that have been outlined to emphasize two major points: (1) the incidence and types of the various toxic complications when either alkylating agents, antimetabolic agents, or combinations of agents have been used, and (2) to present the response of the tumors with the various treatment regimens and to make some observation of the correlation of beneficial response with the toxicity manifested.

Using the alkylating agents alone in 315 cases, leukopenia was seen in 47%, nausea and vomiting in 54%, with a total toxicity in this group of 52%. Significant palliation in this group of 315 cases was realized in about 20% of the patients. Utilizing antimetabolic agents alone, principally 5-fluorouracil in 102 patients, leukopenia was seen in 72%, nausea and vomiting in 32%, stomatitis and enteritis in 50%, and alopecia in 12%, with a total over-all toxicity of about 70%. The palliation achieved in this group was 35%.

Toxicity was most prominent in the group treated with combined drug therapy, seen in 92% of the 83 patients treated. Seventy-five per cent of these manifested a leukopenia, 45% some nausea and/or vomiting, 35% stomatitis or enteritis and 6% alopecia. The palliation of this group was also most prominent with one out of two of the patients treated manifesting a significant antitumor response to the therapy. This seems to bear out the impression so often stated by Curreri and others that toxicity is necessary to achieve a tumor response; and also, that the endpoint in the treatment of solid carcinoma is much more difficult to achieve with the antitumor agents presently available until some toxic manifestation has been seen.[1,7]

In an effort to extend the endpoint of response beyond the two-month figure mentioned earlier in this report, the duration of response of all 500 patients and of the 167 patients who responded to therapy was charted at monthly intervals. It was found that 33% were palliated for the two-months minimum period as outlined in our criteria of response. This represented the total of 167 patients. Thirty per cent, or 150 patients, were palliated for a minimum of three months. One hundred and twenty of the patients were palliated for a period of four months. This represented 24% of the total group. Seventy, or 14%, of the total number responded for five months with significant palliation. Fifty-five, or 11%, of the total group responded for six or more months. Of significance, 55 of the 167 patients who responded at all, or nearly 1 in 3, responded for six or more months. We were thus able to document a sizeable number of patients who had significant palliation with antitumor therapy for a reasonable period of time.

Summary

In our series of 500 patients treated with a variety of antitumor agents, 167 manifested a beneficial response to therapy. Palliation may be significant and prolonged and should be sought for postconventional therapy.

Toxicity is common and serious and can even cause death. It must be carefully watched for and vigorously treated when it occurs.

The need for further study with drug combinations and new agents is necessary to improve palliation.

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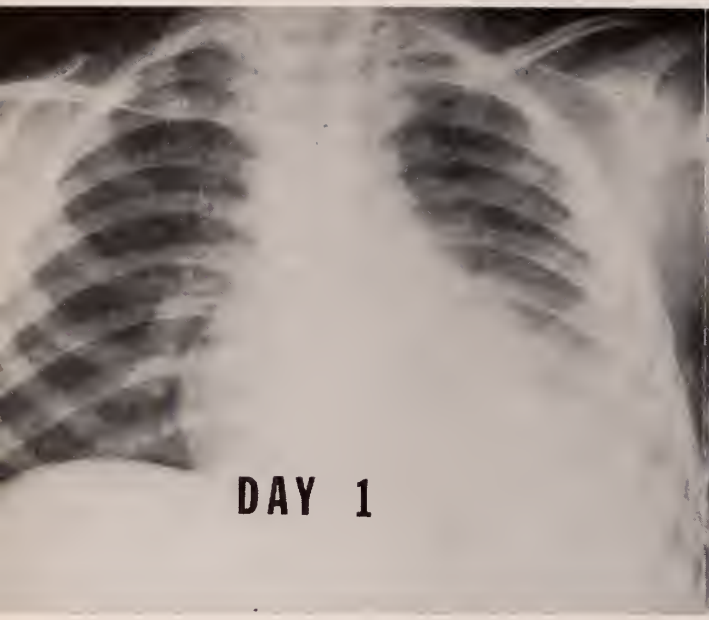

Fig. 1—Admission chest film.

Fig. 2—Chest film 13 days after admission.

one of a series

ROENTGEN RIDDLE . . .

HISTORY: An 18-month-old male entered the emergency room with a 3-day history of cough, fever, irritability, lethargy, anorexia, and diarrhea.

PHYSICAL EXAMINATION: Temperature 104.2 F.; pulse 130; respiration 28 per minute. An acutely ill, pale child was noted. The chest revealed rales and dullness in the left base. The clinical impression was left lower lobe pneumonitis.

LABORATORY: A leukocytosis with a marked shift to the left (40 stabs) was coupled with a hemoglobin of 8.5 gm.

X-RAY: The admitting film was interpreted as left lower lobe pneumonia. A second examination, four days later, showed some resolution and a 1 cm. radiolucency within the clearing infiltrate. The final film, taken 13 days after the initial examination, revealed a multicystic, radiolucent area approximately 3 cm. in diameter. The walls were thin, and no air-fluid levels were demonstrated.

Prepared by Alphonse Richter, M.D., resident in radiology at Milwaukee County Hospital, under direction of John R. Amberg, M.D., radiologist, Department of Radiology at Milwaukee County Hospital.

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Are the Nutritional Needs of the Diabetic Child being Met ?

By VERA E. KERSTELL, M.P.H.

Chippewa Falls, Wisconsin

FEEDING the diabetic child poses problems for the family, problems which they often hesitate to bother the physician about even though they give them real concern. Frequently, questions are put to the public health nurse who in turn asks the district nutritionist for help. Sometimes parents write to the Board of Health. The questions vary and solutions often call for the cooperative effort of physician, family, public health nurse, and the nutritionist.

For example, one mother wrote, "My child has diabetes. The doctor has given him a diet list, but he's eating more of the foods than the doctor prescribed. He never seems to get filled up, especially when he's helping his Dad around the farm after school, and he's taken to eating rye-krisp in between meals. Is this all right? He also likes catsup on almost everything he eats. Doesn't this need to be counted in his diet?"

Another confided in the public health nurse her inability to keep her child on the prescribed diet because "it's so different from what the rest of the family eat." She asked, "Can some of these foods be substituted on the diet list?" Still another mother sought more general information by letter asking only for "any information which you have on diabetes."

Sometimes the family may not know where to seek help with nutrition problems, or are not aware there is a problem. An example was in a family that recently moved from another state. A teacher noticed the girl was pale, thin and not learning well. She called this to the attention of the public health nurse who discovered that, although the girl was diabetic, she was not receiving regular medical care. Later the nurse called a nutritionist to help the mother put the physician's diet instructions into practice.

Miss Kerstell is a nutritionist, District 7, State Board of Health.

Not all questions arise when the child's diabetes is discovered. The parent and child may have a good understanding of the diet and of its importance. The child may be cooperative in following the diet and taking insulin and in accepting his diabetes without feeling different from other children. However, as he grows and develops, his nutrient needs change. Failure to meet his increased growth needs through an increase in the protein and calorie allowance of the diet may force him to choose his menu himself. He may eat more of the needed foods, but all too often he resorts to promiscuous nibbling of food that is handy including sweets.

Sometimes the diet order may take the form of "eat anything except sweets," without designating specific amounts of protein, fat, carbohydrates, and calories. Such an order assumes the family eating pattern includes a variety of all the necessary foods. It also assumes the child has already learned to like and to eat all the foods his body needs and that he will therefore automatically select the right kind and amount. Unfortunately, this is not the case, for appetite and permissive food selection do not insure wise choice.

Where the family food pattern is inadequate, the diabetic child may have difficulty obtaining a proper diet. Preparation of a therapeutic diet in such a home may look like an insurmountable job because it means preparing separate foods in addition to the family meals. Wise guidance, support and understanding often can help the mother improve the diet for the entire family. This is a basic need if the family diet is to be modified to meet the therapeutic need.

However, adequate nourishment for body tissues is not the only requirement for normal growth and development. The parents of a diabetic child must consider their own attitudes. Should they give in to the normal

instinct to protect, to give sympathy and special favors? Should they allow others to do so? This can lead to overprotection and unwise concern that could deprive the child of the emotional rewards so necessary to the nourishment of the whole body, including the personality.

Helping families like these is part of the job of the public health nurse. Often she calls on the district nutritionist of the State Board of Health. Together they visit the family physician to obtain information about the prescribed diet and previous instructions. They visit the family to discuss problems, to interpret instructions, to re-emphasize essential understandings, and to support the family efforts. They keep the physician informed of their role and ask his advice as new problems arise. In all this they try to develop a sound attitude toward diabetes so the diabetic child may grow normally, learn to make wise food choices and develop an adequate food pattern to meet his changing needs.

Seven district nutritionists, under the direction of the State Board of Health's Nutrition Division, are presently giving this consultation service to the public health nurses throughout the state. The service of these nutritionists is also available to physicians on request to the Board's district offices or to the Nutrition Division.

ROENTGEN RIDDLE *continued from page 300*

DISCUSSION: In view of the patient's clinical course of improvement under antibiotic therapy and the enlarging nature of the radiolucency, it was felt that this emphysematous lesion represented a post-inflammatory pneumatocele.

Pulmonary pneumatocele has many names. Postpneumonic air cysts, tension or valve cysts, absorption ring formation, metapneumonic emphysema, alveolar ectasia, localized bullous emphysema and pseudo-cavity are synonyms. The pathogenesis of this localized area of emphysema centers about the subject of bronchostenosis. Complete bronchostenosis ultimately leads to atelectasis of the pulmonary parenchyma distal to the point of obstruction. This phenomenon is frequently encountered in bronchogenic carcinoma, foreign body, bronchial adenomas, and mucous plugs. A bit more subtle, incomplete bronchostenosis leads to emphysema of the distal parenchyma. When, however, one recalls the rhythmic activity of the bronchi and bronchioles in normal respiration, (i.e., the lumen expands on inspiration and diminishes on expiration) it is not difficult to visualize how air might enter through an incompletely stenotic bronchi and yet be trapped during expiration giving rise to the "check-valve" mechanism. Inflammatory exudate and peribronchial edema are the usual causes in the production of pneumatoceles during the clearing of the pneumonitis. Thin-walled, enlarging, ballooned out, multicystic areas, more often without air-fluid levels, are radiologic diagnostic aids. Recently, its increased incidence in staphylococcic pneumonias is reported, and one series reports pneumatoceles in 48 of 83 cases.

The differential diagnosis includes hydatid cysts, diaphragmatic hernias, and pulmonary abscesses. The thin walls and smooth inner borders are aids in differentiating pneumatoceles from pulmonary abscesses.

TREATMENT: No specific therapy is indicated. They spontaneously regress in 2 to 6 weeks. One was reported as having lasted for 97 days.

Sponsored by Section on Pathology
State Medical Society of Wisconsin

CLINICOPATHOLOGIC CONFERENCE

Guest Editor: E. A. BRUCKER, M.D.
Madison, Wisconsin

CASE PRESENTATION*

This 50-year-old white woman was well until the day before admission when she began coughing and vomiting blood. The estimated quantity was 500 ml. It was dark red mixed with bright red clots. She complained also of gnawing epigastric pain for several months, but said she had no black stools until the day of admission.

Her blood pressure was 120/80, temperature 99 F., respirations 16 per minute, pulse 92 per minute and regular. She was a well developed, mildly icteric woman with telangiectases over the face and upper chest. There was a Grade 2 systolic murmur over the precordium, most marked at the apex. The chest was clear except for an occasional inspiratory wheeze. She had a large, nontender, irreducible umbilical hernia. The liver extended 6 cm. below the costal margin and was tender, firm and smooth. The spleen was not felt. There were two healed abdominal surgical scars.

On admission her hemoglobin was 11 gm. per 100 ml., white blood cell count 9,000 per cu. mm. with a shift to the left, mean corpuscular hemoglobin concentration 31.4% and prothrombin time 52%. The next day her hemoglobin was down to 10.4 gm. per 100 ml. The sulfobromophthalein test showed 44% dye retention. The lowest hemoglobin recorded was 9.9 gm. per 100 ml. on the third day.

During the second hospital day she again vomited 500 ml. of blood. The blood pressure fell to 96/54. Her heart rate was 128 per minute. Her general condition appeared satisfactory but she was given blood transfusions. The evening of the second day she was dehydrated in spite of 1,000 ml. of fluid intake and 1,500 ml. of blood in the previous 24 hours. She had small, frequent, watery stools. Bright red blood came through the Levin tube. Early the following morning cyanosis was noted and oxygen was started. Despite emergency procedures the patient died about 8:40 a.m.

In 1954, the patient was admitted to the hospital with swelling of the abdomen. At this time she was obese and was noted to have the umbilical hernia. The liver was thought to be enlarged about 3 cm. below the costal arch. She also had hyperpigmentation of the skin and dilated superficial abdominal veins. Chest, gastrointestinal, and kidney x-ray films revealed no evidence of disease, but the gallbladder was not visualized following the ingestion of the dye. Her hemoglobin was 12.6 gm. per 100 ml. The nonprotein nitrogen was 22 mg. per 100 ml. and the total protein 5.83 gm. per 100 ml. (albumin 2.16 gm., globulin 3.67 gm.). The cephalin flocculation was 3+ on one occasion and negative on another. Total bilirubin was 1.3 mg. per 100 ml. The prothrombin time was 68%. The sulfobromophthalein test revealed 21% dye retention. Alkaline phosphatase was 12 units and the blood ammonia level 130 mcg. per 100 ml.

The diagnosis was Laennec's cirrhosis with ascites.

In December, 1957, she was again admitted to the hospital. She said she felt well. The laboratory studies were as follows: prothrombin time 70%, negative urinalysis, serum glutamic oxaloacetic transaminase 80 units, erythrocyte sedimentation rate 30 mm. in one hour, alkaline phosphatase 26 King Armstrong units, cephalin cholesterol flocculation 1+ in 48 hours, blood glucose 101 mg. per 100 ml., sulfobromophthalein retention 38%, serum total proteins 6.8 gm. per 100 ml. (albumin 3.6 gm., globulin 3.2 gm.), serum bilirubin 0.3 mg., hemoglobin 13.0 gm. per 100 ml., white blood cell count 7,000 per cu. mm., blood urea nitrogen 9 mg. per 100 ml.

Since her last admission she had been in fair health, complaining only of a tight sensation in the upper abdomen and a mild cough. She said she took only an occasional beer and denied the excessive use of alcohol. She had no weight loss. Her temperature had been normal. She denied jaundice and said her appetite had been good.

Discussion

Dr. William Rock: I believe we have a patient with two, possibly three diagnoses, despite the statement that this patient felt fairly well until the time of admission. I feel the patient had some central nervous system impairment that prevented her noticing the disturbances caused by her diseases and caused her to give an unreliable history. In 1954 her liver was found to be enlarged. She had prominent superficial abdominal veins. The reversal of her serum albumin-globulin ratio, the abnormal cephalin flocculation test, the lowered prothrombin time, abnormal sul-

From St. Mary's Hospital.

fobromophthalein retention, elevated alkaline phosphatase test, all indicate serious involvement. In addition she apparently had ascites, possibly obscured by a large umbilical hernia.

During her December, 1957, admission the statement again appears she felt well, but further abnormalities were noted. Her prothrombin time was lowered, the transaminase test was about twice the normal, indicating cellular destruction somewhere in the body. The sedimentation rate, alkaline phosphatase, sulfobromophthalein retention also were elevated. The reversal to normal of her serum albumin-globulin ratio indicated some improvement, but all the other evidence pointed to hepatocellular damage.

At the time of her final admission, in addition to the hematemesis and melena and icterus, there was other evidence of progression of her disease. She had complained of gnawing epigastric pain for several months and a tight sensation across the upper abdomen. The liver had become larger, ascites had developed, her prothrombin time was still lower and the sulfobromophthalein test was more abnormal.

We should now have Doctor Langer demonstrate the x-ray films.

Dr. L. O. Langer, Jr.: The patient's chest x-ray films revealed no evidence of disease. For the fluoroscopic examination of the gastrointestinal tract the patient swallowed the barium mixture without difficulty. There was no gross evidence of esophageal varices.

On the films of the stomach we can see either food particles, blood clots, or probably both in the stomach. In the pyloric channel there is a fairly discrete, sharply demarcated ulcer niche surrounded by an area of soft tissue swelling. This is probably caused by edema associated with an acute ulcer. If we saw this sort of filling defect without the sharp ulcer niche, carcinoma would be the first consideration; but in view of the non-nodularity and well defined margins of the ulcer crater as well as its extra luminal character, the lesion is probably benign. Except for an indentation on the base of the bulb which is due to mucosal edema, this structure is normal as is the duodenal loop.

There is a pyloric channel ulcer which looks benign. The remainder of the stomach is filled with clots and/or food particles, but appears grossly normal. I do not see any significant duodenal abnormality.

Doctor Rock: The patient was conservatively treated, and perhaps at the time her condition precluded vigorous diagnostic procedures. It should be mentioned that with patients bleeding from the gastrointestinal tract who have cirrhosis or other severe liver disease, the use of the Sengstaken tube should be given consideration. On the evening of the second day the patient pulled out her Levin tube. In the presence of severe liver disease the lack of cooperation of patients is common. This patient probably was in some degree of hepatic coma.

It should be brought to our attention that with massive gastrointestinal bleeders, very close observation of the patient by physicians, particularly one who coordinates the work of all involved, is extremely important; and here again it is well demonstrated that in the early morning most bleeders get in trouble. Although this patient died at 8:40 a.m., one can be sure that she probably was in trouble between 2 a.m. and 5 a.m. The patient suddenly died after appearing fairly stable, but cyanotic.

I do not believe she had obstructive biliary tract disease. There was no history of drug ingestion or exposure to liver toxins. Wilson's disease, a defect in copper metabolism, can cause damage in the liver, kidney, and the central nervous system; but this patient did not present the other features of this disease. Acute hepatitis, acute yellow atrophy of the liver, hemochromatosis and heart disease must be given consideration. All of these can cause jaundice.

She had a pyloric ulcer that was benign and could have caused the bleeding that brought her to the hospital. The evidence, however, points more to bleeding varices than to pyloric bleeding. The likelihood of carcinoma is not great because of the long history of gastrointestinal disease. The Mallory-Weiss syndrome, a rent in the gastric mucosa from prolonged vomiting and retching, can be excluded because her terminal illness began with vomiting blood. Granulomas, such as tuberculosis, sarcoidosis, histoplasmosis and even regional enteritis, can cause ulceration in this area as can malignant lymphoma. The laboratory data do not support these diagnoses.

Periarteritis nodosa has caused pyloric and antral ulcerations. The pancreatic tumors such as the Zollinger-Ellison types, which are malignant and cause extreme hypersecretion of the stomach that produces ulcers, are not likely.

Sudden death in patients such as this one is usually caused by cardiac disease, shock or perforation of a viscus. The heart disease could be myocardial infarct, an infarct from anemia or an arrhythmia caused by repeated strain on a heart that perhaps had some arteriosclerotic injury previously. There could have been shock from acute blood loss or from perforation of a viscus. Acute septicemia must also be considered because such patients do not have great resistance, particularly to Escherichia coli organisms. They can go into shock and die suddenly. This diagnosis is seldom overlooked because the patients usually have obvious signs of septicemia.

In summary, I believe this patient undoubtedly had Laennec's cirrhosis, portal hypertension, and bleeding esophageal varices. She also had a benign pyloric ulcer which could have been bleeding.

Differential Diagnosis

Dr. E. A. Brucker: We might profitably spend a few minutes on laboratory tests used in studying a patient with bleeding from the upper gastrointestinal tract. The hemoglobin and hematocrit reading are still the two most common tests used to determine blood loss. However, the hemoglobin determination may be misleading because of the hemoconcentration followed by hemodilution that occurs in any patient with a sudden massive hemorrhage. The hematocrit, which measures the ratio of red blood cells to serum, reflects more closely the degree of anemia than does hemoglobin determination. It is the quickest and easiest to use. Another valuable test is the determination of the blood ammonia level. This is helpful in differentiating bleeding from cirrhosis from that due to other causes, such as ulcers or tumors. The normal blood ammonia level is approximately 80 mcg. per 100 ml. However, most cases of bleeding associated with cirrhosis have levels of 120 mcg. per 100 ml. or above. The explanation of this increase of blood ammonia level in cirrhosis is given in Figure 1. Blood in the gastrointestinal tract is attacked by urea splitting organisms

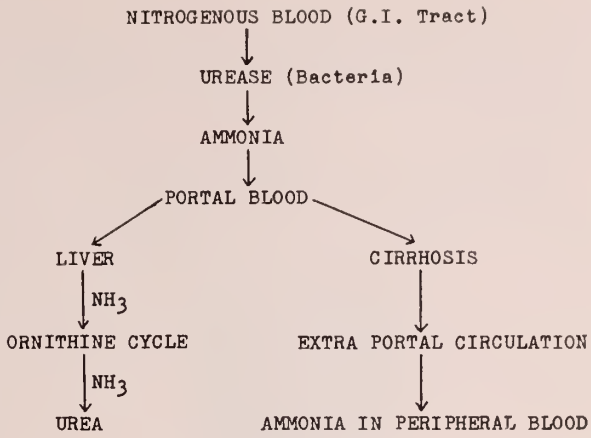

Fig. 1—Blood ammonia.

TABLE 1—*Common causes of gastrointestinal hemorrhage*

	Causes	Percentage
(1)	Peptic Ulcer	40
	Stomach	9
	Duodenal	30
	Stress Ulcers	1
(2)	Benign Diseases (Other than Peptic Ulcers)	31
	Cirrhosis with Varices	22
	Hemorrhagic Gastritis	2
(3)	Malignant Disease	12
	Esophageal Stomach Pancreatitis	9
(4)	Blood Dyscrasia	8.5
	Leukemia (Acute)	6
	Others	2
(5)	Other	5
	Terminal Uremia	0.5
	Unknown	1
(6)	*Hematemesis without lesion*	10–25
	Superficial erosive gastritis	

TABLE 2—*Bleeding in Cirrhosis*

Occurs 25–30% of cases	Percentage
(1) Rupture Varices (Esophageal)	20
(2) Rupture Varices (Gastric)	5
(3) Peptic Ulcer	5–15
(4) Epistasis	9–19
(5) Hemorrhagic Gastritis	2–4

which convert the nitrogenous substances into ammonia. This is then transported normally over the portal circulation to the liver where it enters the ornithine cycle where the ammonia is utilized in the formation of urea. However, in patients with cirrhosis a large portion of the blood is diverted through the gastric and esophageal vessels back into the circulation so that the ammonia is not properly removed. This elevates the levels in the peripheral circulation. It is to be noted, however, that large doses of antibiotics can sterilize the bowel and prevent this reaction from occurring.

In Table 1 are listed the most common causes of upper gastrointestinal hemorrhage. Hematemesis caused by superficial erosive gastritis now is being recognized more fre-

one of a series

Medical Stamps

ANTONIO GROSSICH
(1849–1928)

Physician, statesman. Fiume honored him in 1919 with stamp #B16.

A. SAPE TALMA
(1847–1918)

Studied at his native city Utrecht. In 1876 he received the chair of pathological anatomy, later of internal medicine. He developed an operation, which bears his name, for the elimination of ascites in cirrhosis of the liver. Netherlands shows him on stamp B87.

• • •

ACKNOWLEDGMENT: Reproduced by permission of Oscar Gottfried, New York City, author of "Doctors Philatelic," bibliography of nearly 300 illustrative medical stamps, which is available at $3.00 from The New York Physician, 1440 Broadway, New York 18, N. Y.

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quently. Ten to 25% of the instances of upper gastrointestinal bleeding are due to this lesion.

The most frequent causes of bleeding in cirrhosis are listed in Table 2. It is interesting to note that approximately 25 to 30% of all patients with cirrhosis of the liver will bleed. In 5 to 15% of the patients, peptic ulcers are the cause of the bleeding. Thus a patient with cirrhosis of the liver has a greater chance of having a peptic ulcer than a patient without this disease.

Anatomical diagnosis:

(1) Portal cirrhosis.
(2) Superficial errosive gastritis.
(3) Benign gastric ulcer.

In the microscopic sections from the stomach there were small areas of hemorrhage in the mucosa with minute capillaries identified at the surface of the mucosa covered by a thin layer of fibrin and red blood cells. In the sections from the liver a fairly typical picture of portal cirrhosis with a large amount of fat present in the liver cells was seen. In step sections through the gastric ulcer no evidence appeared of erosion of any blood vessel in this area. The ulcer edge and base were that of typical chronic peptic ulcer.

In summary, this was a patient with portal cirrhosis and acute superficial erosive gastritis. She had obvious cirrhosis which presented no problem in diagnosis. The real problem was that of determining the source of the bleeding. She had two potential areas: the peptic ulcer and the esophageal varices. However, neither was the cause of bleeding. It is possible that a more vigorous diagnostic approach would have ascertained the cause of the bleeding. Subtotal gastric resection improves or cures 90% of the patients with hematemesis with no obvious lesions. There was a patient here three months ago with this type of lesion that was cured by subtotal gastric resection. This lesion must always be considered when no specific cause for bleeding can be found. Its etiology is unknown.

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720 South Brooks Street.

Editors
HARRY BECKMAN, M. D., Marquette University
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COMMENTS ON TREATMENT

Aspirin Substitutes

By HARRY BECKMAN, M.D.
Milwaukee, Wisconsin

SALICYLAMIDE (Salamid, Salacim, Dropsprin). Perhaps it may be possible to substitute this agent successfully for aspirin in equivalent dosage in most situations, but the evidence is by no means definitive as yet. The study of Vignec and Gasparik[1] (1958) was favorable to the drug, but it was severely criticized by Woodbury[2] (1958) for its unsupported claim that aspirin is twice as toxic as salicylamide, for its unwarranted extrapolation of findings in mice to men, and for its misleading implication that comparable dosages of the two drugs had been used in the study. It seems to be established fact that individuals sensitized to aspirin may sometimes take this substitute drug with impunity, but there is apparently little difference between the two compounds in other aspects of side-actions and toxicity, though Quick and Clesceri[3] (1960) failed to observe the effect on prothrombin time that is characteristic of aspirin.

SODIUM GENTISATE (Casate sodium, Gentasol, Gensalate, Gentisan). A thorough pharmacologic study of sodium gentisate has not been made, but we do know that it is well absorbed when given orally and recoverable in the urine to the extent of 60 to 80% as glucuronates and sulfuric acid conjugates. Antipyretic action has not been demonstrable in animal experimentation or in man, and usefulness as general analgesic in aspirin-like employment has not been demonstrated, but the drug apparently does have antirheumatic action comparable to that of the salicylates. Clarke and associates[4] (1953) found that the temperature and erythrocyte sedimentation rate in rheumatic fever actually returned to normal earlier under gentisates than under salicylates. Sodium gentisate seems to be well tolerated for months without the side-actions characteristic of the salicylates. One instance of granulocytopenia and lymphocytosis has been reported.

CHOLINE SALICYLATE (Arthropan, Actasal) and CALCIUM ACETYL SALICYLATE CARBAMIDE (Calurin). The claim is made that these preparations are absorbed more rapidly than aspirin and hence provide an analgesic effect more quickly. But what is the reason for such great haste in the situations in which salicylates are used? In the ordinary headachy, aches-and-pains sort of thing for which most aspirin is ingested the onset of relief, be it psychically engendered or not, occurs usually within 30 to 45 minutes and that is fast enough; whereas in the more serious maladies it is absurd to claim advantages for compounds that may at best advance the advent of relief no more than a few minutes. Furthermore the aspirin substitutes are more expensive than the classic drug.

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The New President

LEIF H. LOKVAM, M. D.

Dr. Leif H. Lokvam, who took office as president of the State Medical Society of Wisconsin in May, received the A. B. degree in 1928 and the M. D. degree in 1931 from the University of Wisconsin. He was born in 1907 in Minnesota and was raised in Eau Claire, Wisconsin, where he graduated from high school. He interned at Ravenswood Hospital, Chicago, Illinois, practiced in Burlington, Wisconsin, until 1934, when he associated with the Kenosha Clinic. He has practiced in Kenosha since that time. He served as secretary and president of the Kenosha County Medical Society and as chief of the medical staff of Kenosha and St. Catherine's hospitals. He served as a member of the Council from the second district for two terms, from 1954–1960, as Vice Speaker of the House of Delegates in 1958, as Speaker of the House of Delegates in 1959, and as President-Elect in 1960. He is a member of the Wisconsin Surgical Society, and is a fellow of the American College of Surgeons. Doctor Lokvam is a member of the Chamber of Commerce and has served on its board of directors, he serves on the council of the Boy Scouts of America as chairman of the health and safety committee, has served on the Polio Foundation Board, and in fund raising for Red Cross and Community Fund. Doctor and Mrs. Lokvam have three daughters, Mrs. Stuart Updike, Sonja and Kirsten, and a son, Leif Christian.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

How to Stand Up and Scream

IT'S A HAPPY FACT that people in our democracy can exert political pressure. The *vox populi*, to mix a metaphor, is what butters the politicians' bread, and no one knows it as well as they do. The trick, as far as the ordinary citizen is concerned, is to make his voice heard so that the vote of his representative is cast the way he—and possibly the majority—wants it cast.

Letters from individual voters tell the elected official what the "folks back home" are thinking. It reflects the feeling of the people who put him in office and can keep him there.

Your letter is the most cogent, most direct influence you can bring to bear on the decision in any issue. Through your letter to your legislator, you let it be known what you like and don't like in government.

When you feel strongly about an issue, write to the person who will vote on the decision. When you write, be sure your letter is worth consideration. Too often our solons receive "crank mail" which abounds with personal abuse, foul language, and insults. Such letters harm the cause they favor because of the resentment they produce.

So that your opinion will be heard and considered seriously, the following helpful hints are offered for writing to politicians: (or statesmen, if they happen to agree with you)

Address him by his right name and title. Don't confuse a Senator with a Representative. If you aren't sure, your local librarian can direct you to a reference work that will tell you the proper form of address.

Be yourself. Use your own letterhead, and write as though you were talking to him. He is human, and nobody enjoys stilted, high-flown or oratorical language.

Be specific. Make your letter brief, to the point, and local. Tell how a national issue affects your community and your profession. If you are for something, say so emphatically, but directly. If you oppose something, say so openly, without circumlocution and without cover-up reasons.

Be polite. A member of any legislative body deserves respect, regardless of your personal opinion of him, his capabilities, or his antecedents. You will get nowhere by commenting on him personally or by threatening adverse political action. This is what characterizes "crank mail."

Be appreciative. Thank him for his votes that you approve, compliment him on his good speeches and praise his staff, too, where applicable. Legislators, being human, warm up to approbation when it is obviously sincere.

Request reasonable action. The only thing your representative can do for you is to accomplish practical, political action. He is elected to give you that service, and you have a right to request it. Don't ask him for something he can't do, or for something that is clearly impractical.

Ask where he stands. After you have explained your position, you are entitled to know what he thinks about an issue. Most legislators will reply to your letter, either personally or through a secretary. His reply to you will be a good indication of what you can expect from your representative.

Make your voice heard when you stand up and scream. Make it heard with dignity and with decency, and it will be heard with effect.

Notable Conference

THE FIRST STATEWIDE conference on "Medical Aspects of Mental Retardation," sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin, on June 21 merits the attendance of every physician in the state. Co-sponsored by every significant organization in Wisconsin dealing with the problems of mentally retarded children, the program presents a distinguished panel of speakers lecturing on both medical and nonmedical aspects of mental retardation.

There are few problems more perplexing than those of mental retardation. Because of the profound effects of his decisions, both for the child and the family, the physician assumes a role that requires sensitivity as well as scientific competence. Greater familiarity with the work being done in this field will unquestionably give doctors faced with cases of mental retardation confidence to handle with authority and wisdom the many and involved problems.

The conference to be held at Brooks Memorial Auditorium of Marquette University in Milwaukee is chaired by Dr. H. Kent Tenney of Madison, past president of the State Medical Society, and has been certified for six hours of Category I credit for members of the American Academy of General Practice. Program details may be examined on another page in this issue of the *Journal.*

WISCONSIN HEART ASSOCIATION ANNUAL MEETING

JUNE 10, 1961, SATURDAY, 8:30 A.M.–5:00 P.M.

BROOKS MEMORIAL UNION—MARQUETTE UNIVERSITY—MILWAUKEE

Guest Lecturers:

S. Gilbert Blount, Jr., M.D., Professor of Medicine, Head, Division of Cardiology, University of Colorado School of Medicine, Denver, Colorado.

John A. Campbell, M.D., Professor and Chairman, Department of Radiology, Indiana University School of Medicine, Indianapolis, Indiana.

Denton A. Cooley, M.D., Associate Professor of Surgery, Baylor University College of Medicine, Houston, Texas.

Dr. Carl S. Winters, luncheon guest speaker, appearing through the courtesy of General Motors Corporation.

Malcolm F. Rogers Lecturer.

H. J. C. Swan, M.D., Mayo Clinic, Rochester, Minnesota.

Willem J. Kolff, M.D., Director, Dept. of Artificial Organs, Cleveland Clinic, Cleveland, Ohio.

THE MEDICAL FORUM

House Of Delegates Urges Prompt Action On Implementation Of Kerr–Mills In Wisconsin

"The most immediate task confronting all of medicine and more specifically the State Medical Society of Wisconsin . . . is the implementation of Kerr–Mills legislation."

This statement from the report of the Special Committee of the Council which visited Washington, D.C., in March, sounded the keynote for the 120th annual meeting of the State Medical Society in Milwaukee May 2–4.

"Neither the magnitude nor the significance of this program can be underestimated," added the report of the Commission on Public Policy. "Wisconsin medicine supports this approach, and it now becomes our responsibility to rally the legislature and others to create in this legislation an effective instrument of public health."

The bills in question are 550, A. and 466, S.—now pending in the Wisconsin legislature—which create Health Assistance for the Aged (HAA) under the Federal Kerr–Mills Act.

Members of the House of Delegates also heard speeches by Outgoing President Dr. E. D. Sorenson, Incoming President Dr. Leif H. Lokvam, and Council Chairman Dr. James C. Fox, urging active support of the HAA legislation.

At the same time that the House pressed for early passage of the Wisconsin legislation, it called upon the Society for renewed opposition to Forand-type legislation as embodied in the major proposals before the U.S. Congress (Bills H.R. 4222 and S. 909) known as the King–Anderson proposals.

STATE MEDICAL SOCIETY LEADERSHIP for three years is represented above by, left to right, Dr. Leif H. Lokvam, Kenosha; Dr. E. D. Sorenson, Elkhorn; and Dr. Nels A. Hill, Madison. Doctor Lokvam was installed president at the annual meeting; Doctor Sorenson is immediate past president; and Doctor Hill is president-elect.

Approve Twelve Resolutions At House Of Delegates Session

The following action was taken by the House of Delegates on resolutions presented before it at the 1961 annual meeting:

Resolution No. 1

(Approved)—limiting participation in the activities of the County and State Medical Society to members and invited guests, with all acceptable nonmember physicians to be expressly invited to join the Society and participate.

Resolution No. 2

(Combined with Resolution No. 9 in a substitute resolution offered by the Reference Committee and approved)—instructing legal counsel and staff to draft changes in the bylaws to limit tenure of office and committee memberships and commission memberships, with the exception of delegates to the American Medical Association, to three consecutive terms. The draft is to be submitted to the House of Delegates at its next session.

Resolution No. 3

(Substitute resolution offered by the Reference Committee and approved)—stating that appointments to State Medical Society offices should, insofar as is practicable, be cleared with an appropriate representative of the county medical society of which the appointee is a member.

(Continued on next page)

GUEST SPEAKER DR. R. C. HORN, JR., Detroit, Michigan, talks at a Roundtable Luncheon at the annual meeting in Milwaukee. Doctor Horn was one of 22 out-of-state guest lecturers who joined 41 members of the medical school faculties in presenting the various scientific programs at the annual meeting.

Approve Twelve Resolutions At House of Delegates Session

(Continued from page 311)

Resolution No. 4

(Note voted on)—Speaker of the House Dr. E. J. Nordby previously announced the appointment of a six-man committee for "selection and supervision of a management survey authorized in 1960." If conducted, the survey is to study the structure, function and management of all activities of the State Medical Society and its component county societies, including those of the Blue Plans, and is to be financed by a special assessment of $25 per member of the State Medical Society. The members of the six-man committee are: Drs. Henry M. Suckle, Madison; R. W. Ashley, Kenosha; L. W. Schrank, Waupun; J. W. Boren, Jr., Marinette; Edgar End, Wauwatosa; and J. P. Conway, Milwaukee.

Resolution No. 5

(Approved)—expressing appreciation to Dr. Edward R. Annis, Miami, Florida, for his efforts in presenting medicine's stand in reference to socialized medicine.

Resolution No. 6

(Amended by Reference Committee and approved)—encouraging the use of standard report forms in answering inquiries on nonmedical insurance policies, with a fee commensurate with the work involved to be charged for the completion of such reports.

Resolution No. 7

(Rejected)—asking that the delegates to the American Medical Association obtain justification of dues increase by the AMA, and lacking such justification, to oppose any dues increase. The Reference Committee said it knew of no reason to doubt the judgment of the AMA delegates in their action.

Resolution No. 8

(Approved)—instructing legal counsel and staff to draft changes in the bylaws to designate major State Medical Society Committees, Divisions, or Councils and to eliminate the holding of multiple positions by individuals on these groups.

Resolution No. 9

(Combined with Resolution No. 2)—See discussion under Resolution No. 2 for final action.

Resolution No. 10

(Approved)—that the Society enlist the aid of state governmental units to formulate a plan of study of state tuberculosis control that should result in recommendations for both state and county TB control.

Resolution No. 11

(Referred to Commission on Hospital Relations and Medical Education)—recommending that the Council on Medical Education and Hospitals of the AMA formulate acceptable two-year progressive training programs, other than the present pilot program, for general practice residencies.

Resolution Relating to Chiropractors

(Approved)—in the interests of providing sound health guidance to the people of the state, that:

a. The Society appeal to the legislature and state and local law enforcement officers for immediate and full enforcement of laws regarding use of the title "Doctor" by all who treat the sick.
b. The Society challenge improper use of the title wherever it occurs.
c. A statement, in manner approved by the Council, be prepared, giving an official definition of "chiropractic," pointing out the limitations imposed by law on its practitioners.

Resolution on Chiropody

(Approved)—requesting Wisconsin's delegates to the AMA to seek a thorough review and study of chiropody by the AMA to establish agreement as to its definition, the scope and quality of its education, and uniformity as to its standards of practice.

Resolution on Social Security Health Care

(Approved)—that the Society commend those members of Congress and all others who have opposed the trend toward a socialistic program of national compulsory political medicine, and endorse and support implementation of the AMA's ten-point program on aging throughout the state.

Resolution on County Medical Society Speaking Programs

(Approved)—that each county society form speakers bureaus to present medicine's views and stands on state and national issues relating to health and medicine to local groups, and that all physicians actively participate in community activities.

Resolution on Endorsements of Social Security Mechanism

(Approved)—Since it was reported that the national convention of the YWCA and the General Assembly of the United Presbyterian Church are considering resolutions to endorse health care of the aged via social security, members of the Society are urged to take immediate steps to present medicine's viewpoint to YWCA leaders and Presbyterian ministers and elders in Wisconsin.

List Elections, Appointments Made At 1961 Annual Meeting

Dr. Leif H. Lokvam, Kenosha, became president of the State Medical Society, succeeding Dr. E. D. Sorenson, Elkhorn. Formerly Second District Councilor, vice-speaker, and speaker of the House of Delegates, Doctor Lokvam was named president-elect in 1960.

New president-elect is Dr. Nels A. Hill, Madison. He is former Third District Councilor and serves as assistant treasurer for the State Medical Society.

Others Elected To Office Are:

Speaker—Dr. Robert Callan, Milwaukee

Vice-Speaker—Dr. H. W. Carey, Lancaster

A.M.A. Delegates—
- Dr. A. A. Quisling, Madison
- Dr. Roman E. Galasinski, Milwaukee

A.M.A. Alternates—
- Dr. William B. Hildebrand, Menasha
- Dr. George Collentine, Jr., Milwaukee

Councilors (by district)—
- 3rd—Dr. E. J. Nordby, Madison
- 4th—Dr. E. M. Dessloch, Prairie du Chien
- 5th—Dr. P. B. Blanchard, Cedarburg
- 6th—Dr. H. J. Kief, Fond du Lac
- 12th—Dr. Donald M. Willson, Milwaukee
- Dr. William J. Houghton, Milwaukee

Committee Appointments:

Cancer—Dr. J. W. Boren, Jr., Marinette; Dr. M. W. Stuessy, Broadhead; and Dr. G. H. Williams, Marshfield. Dr. Paul Cunningham, Appleton, was reappointed chairman.

Public Policy—Dr. J. F. McIntosh, Madison. Dr. R. G. Zach, Monroe, was appointed chairman.

Grievances—Dr. H. J. Belson, Manitowoc; Dr. R. R. Richards, Eau Claire; and Dr. T. J. Nereim, Madison. Dr. E. D. Sorenson, Elkhorn, was designated chairman.

Public Relations and Communications—Dr. D. M. Willison, Eau Claire; Dr. J. S. Devitt, Milwaukee; and Dr. Louis Olsman, Kenosha. Doctor Willison was reappointed chairman.

Scientific Medicine—Dr. G. W. Collentine, Jr.

Hospital Relations and Medical Education—Dr. C. J. Picard, Superior; Dr. G. B. Murphy, Jr., La Crosse; and Dr. Edgar End, Milwaukee. Dr. R. S. Gearhart, Madison, was reappointed chairman.

Dr. Nels A. Hill Of Madison Is New SMS President-Elect

Dr. Nels A. Hill, Madison, was named president-elect of the State Medical Society at the annual meeting in Milwaukee May 2–4.

Doctor Hill will serve one year as president-elect, and then become president of the society.

A 1929 graduate of Harvard Medical School, he served his internship at Wisconsin General Hospital, Madison, and completed his residency at Wisconsin General and the Lahey Clinic, Boston, Mass. Doctor Hill is a specialist in internal medicine.

Active in State Medical Society affairs, he currently serves as assistant treasurer and has just completed eight years as Councilor for the Third District. He has also served on the Commission on Scientific Medicine, and is treasurer for Wisconsin Physicians Service.

NEW FIFTY YEAR CLUB MEMBERS, who received their awards at the annual dinner in Milwaukee May 3, are, front row, left to right, Dr. William G. Domann, Menomonee Falls; Dr. Otto F. Goetsch, Hustisford; Dr. John P. Koehler, West Bend; Dr. Henry A. Sincock, Superior; and Dr. Helen A. Binnie, Kenosha. Back row, left to right, are Dr. Albert J. Randall, Kenosha; Dr. Elmer S. Johnson, Oregon; Dr. Isadore Franklin, Milwaukee; Dr. Jay C. Brewer, Jefferson; Dr. Cecil B. Hake, Milwaukee; and Dr. George J. Schweitzer, Milwaukee.

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Major Policy Decisions Made During 1961 Annual Meeting

With 13 committees and commissions submitting reports and recommendations to the House of Delegates in the 1961 session in Milwaukee, numerous measures of consequence to Wisconsin physicians were approved.

Some of the major actions and reports follow:

Personal Service Corporation

Society approval was given to a Personal Service Corporation bill (587, A.) in the legislature which would permit certain self-employed persons, including physicians, to establish retirement plans and defer tax on income so allocated until the time that its benefits are received.

Dual Use of Institutions

The following recommendations were approved in regard to dual use of institutions for the care of tuberculous and nontuberculous patients:

a. Admission policies should be determined in cooperation with the local county medical society.
b. County societies should establish a medical advisory committee to assist in the establishment of admission policies, visiting staff appointments and physician treatment privilege.
c. This committee would also serve as a liaison group between the institution and the county society.

Hypertension Screening Program

County societies are urged to utilize hypertension screening facilities operated by the State Board of Health. Final determination to use the mobile program rests with the county society.

Mental Retardation

A medical conference on mental retardation, to be held at Brooks Memorial Auditorium, Milwaukee, on June 21, was approved. This is the initial event in a plan of the Commission on Scientific Medicine to present special statewide conferences in areas of medical practice of concern to the profession.

Postgraduate Teaching

The Society's speakers service for county medical societies provided 72 speakers for programs this year. Attendance at Circuit Teaching Programs of the Society during the past year was 305.

Annual Dues

Annual State Medical Society dues were raised $15 a year, to $90 starting in 1962.

Bicillin Program

A change was accepted in the state Bicillin program which eliminates mandatory confirmation of the original diagnosis of rheumatic fever, urging instead voluntary use of confirmation techniques. Under new procedures, any licensed physician in the state may register his patient for participation by filing a registration report, based on the Jones Criteria Test for Rheumatic Fever. It will be the responsibility of the family to establish financial need.

Medical Service Centers

Study was authorized on a proposal to establish medical service centers throughout the state to give people reliable information and assistance in obtaining medical care and solving related personal health problems.

Survey of Public Health Programs

A survey, in cooperation with the State Board of Health, of current public health programs in Wisconsin, and new areas of responsibility which might lead to a more unified direction and improved public health services in the state was approved.

Tuberculosis Mass Screening

Mass screening of potentially exposed persons by the county medical society in cooperation with public health authorities is recommended in any school or similar situation where a known case of tuberculosis has been revealed.

Training in Hypnosis

Wisconsin's medical schools are urged to develop more comprehensive undergraduate and postgraduate training regarding the medical use of hypnosis.

Public Information Programs

An increased public information program was authorized, including explanation of medicine's viewpoint on economic planning for health care and preservation of present standards of medical care.

Television Programs

County medical societies are encouraged to work directly with local television stations in the development of appropriate public information programs.

Medical Student Recruitment and Internships

Immediate action was urged to attract more qualified medical school applicants. A conference on internships is being held May 20 in Madison to discuss the internship problem in Wisconsin.

Polio Immunization

Every county society was urged to give the widest possible promotion to the use of polio vaccine as a safeguard against epidemic.

Tetanus Immunization

Promotion of tetanus immunization for adults was approved.

NEW FOUNDATION TRUSTEES are shown above with Dr. W. D. Stovall, Madison, president of the Charitable, Educational and Scientific Foundation. Warren E. Clark, Milwaukee, and Robert B. L. Murphy, Madison, examine an artist's sketch of proposed Presidential Gardens, for the grounds of the State Medical Society headquarters in Madison.

Museum of Medical Progress Now Open

The Museum of Medical Progress at Prairie du Chien is now open for the 1961 season.

Many new displays have been added this year, and a new administration building, with facilities for the public as well as working space for the curator, has been completed.

Exhibits tell of medical progress over a three-century span, from Indian remedies to space age medicine.

A special attraction during May—of great educational value to the many school groups visiting the museum—is a model transparent woman on loan from the American Medical Association. The various organs of the body are shown in synchronization with a tape recorded explanation of physiology.

The museum is open daily, from 9 a.m. to 5 p.m.

RECEIVING GRANTS TOTALING $28,039.42 are Dr. John Hirschboeck, left, and Dr. John Z. Bowers, center. The presentations are being made by Dr. A. H. Heidner, West Bend, chairman of the Wisconsin committee of the American Medical Education Foundation. Doctor Hirschboeck accepted $16,442.91 for Marquette University School of Medicine, and Doctor Bowers accepted $11,596.51 for the University of Wisconsin Medical School.

New Trustees Of Foundation

Three prominent Wisconsin residents have been named trustees of the Charitable, Educational and Scientific Foundation of the State Medical Society.

They are Warren E. Clark, Milwaukee, agent for Northwestern Mutual Life Insurance Company; E. E. Bryant, Stoughton, president of Nelson Muffler Corporation; and Robert B. L. Murphy, Madison, an attorney and president of the State Historical Society of Wisconsin.

Report Reveals Progress Of Wisconsin Physicians Service

The year-end balance sheet of Wisconsin Physicians Service shows a substantial increase in surplus (total reserves) of $263,426.61.

This report, from records audited by Donald E. Gill and Company, Madison, certified public accountants, shows some other important facts:

Total reserves increased to $1,454,938.14.

Premium income for 1960 was $9,144,159.83, an increase of more than $1,450,000 over 1959.

83.22 per cent of surgical-medical earned income was paid in benefits compared with 87.40 per cent in 1959.

The ratio of hospital benefits to earned income was 92.06 per cent compared with 119.46 per cent the previous year.

Administrative expenses continued their downward trend to 12.08 per cent as compared with 13.24 per cent in 1959.

As WPS celebrates its 15th anniversary, the amount of paid benefits since its inception in 1946 has been $43,869,276.70.

Attendance

Total attendance at the 1961 annual meeting was 3,327, compared with 3,238 in 1960.

Making up the total registration were 1,557 member physicians; 52 physician guests; 320 interns, residents and medical students; 548 exhibitors; and 850 guests—nurses, physicians wives and others.

The tabulation was provided by the Milwaukee Association of Commerce Convention Bureau.

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Conference On Mental Retardation June 21

A conference on the medical aspects of mental retardation will be held Wednesday, June 21, at Brooks Memorial Auditorium, Marquette University, Milwaukee.

It is sponsored by the Society's Charitable, Educational and Scientific Foundation through a grant of the Wisconsin Council for Mentally Retarded Children.

The program will start at 10 a.m. with a discussion of its aims by Dr. H. Kent Tenney, Madison, conference chairman.

At 10:15 "Medical and Nonmedical Evaluation of the Growing Child" will be discussed by Dr. Reynold A. Jensen, Minneapolis, and Eldon Bond, Ph.D., Milwaukee.

"Counseling and Planning with the Family" will be the topic at 11:15 for Dr. A. A. Lorenz, Eau Claire, Dr. Leonard J. Ganser, Madison, and G. I. Wallace, Madison.

Moderator for the afternoon session will be Dr. E. D. Schwade, Milwaukee. "Case Presentations and Discussion" will be given at 2 p.m. with Dr. Henry Veit, Milwaukee, talking about institutionalized care and a general discussion on cases suitable for home care.

At 4 p.m. various aspects of research in the field of mental retardation will be covered by Dr. Harry Waisman, Madison, Dr. David Smith, Madison, and Robert Erdman, Ed.D., Milwaukee.

A review of the conference will be held at 5 p.m., with adjournment at 5:30.

A BLAST AT CHIROPRACTIC was delivered by Dr. Robert Zach, Monroe, at the opening session of the House of Delegates. He is shown above explaining a chiropractic device which was seized in Wisconsin by the Food and Drug Administration and branded a fraud. The House later passed a resolution calling for education of the public and law enforcement officials on the strict limitations the law places on the practice of chiropractic in Wisconsin.

Chiropractic Resolution

A resolution calling for the strict enforcement of laws regarding use of the title "Doctor" by all who treat the sick and drafting of a statement giving a definition of "chiropractic" and pointing out the legal limitations imposed on its practitioners, was passed by the House of Delegates.

The resolution is printed in full on the following page.

Narcotics Registration Due Before July 1

Every physician who distributes, dispenses, gives away, or administers narcotic drugs to patients must register and pay a tax of $1.00 on or before July 1.

Registration is accomplished through the Director of Internal Revenue, Milwaukee 1, Wis. Direct any correspondence to that address.

Physicians who change address should also notify the Internal Revenue Service promptly.

Physicians may be subject to penalties for overlooking either the registration or the tax. Registration is usually done in January.

AMA OFFERS FILM ON RETIREMENT REWARDS

The opportunities and rewards of retirement are dramatically presented in a new film, "Old Man Young," which is now available from the American Medical Association.

The film is available for showings sponsored by medical societies from the American Medical Association, 535 North Dearborn Street, Chicago 10, Ill. The only charge is return shipping cost.

PAST PRESIDENTS of the State Medical Society were guests of Immediate Past President Dr. E. D. Sorenson at a dinner in Milwaukee during the annual meeting. Front row, left to right, are Dr. K. H. Doege, Marshfield; Dr. L. H. Lokvam, president, Kenosha; Doctor Sorenson; Dr. Nels A. Hill, president-elect, Madison; and Dr. A. J. McCarey, Green Bay. Back row, left to right, are Dr. A. H. Heidner, West Bend; Dr. J. W. Fons, Milwaukee; Dr. W. D. Stovall, Madison; Dr. Gunnar Gundersen, La Crosse; Dr. H. E. Kasten, Beloit; Dr. J. C. Griffith, Milwaukee; Dr. E. L. Bernhart, Milwauke; Dr. M. A. McGarty, La Crosse; Dr. R. P. Sproule, Milwaukee; and Dr. H. Kent Tenney, Madison.

A Resolution Relating To Chiropractors In Wisconsin

WHEREAS, The unrestricted use of the title "Doctor" in health care is a privilege reserved by the Legislature for those who have attained certain high standards of comprehensive education, learning and competence in the care and treatment of the whole human being; and

WHEREAS, There is widespread willfull misuse of the title "Doctor," in clear and flagrant violation of Wisconsin statutes, by many limited licensees and others who treat or assist in the treatment of the sick; and

WHEREAS, The Wisconsin Supreme Court, in an opinion confirming the prohibition against the use of the title "Doctor" by chiropractors, declared: "The title does not aid him in the treatment, it merely aids him in securing the confidence of prospective patients and in inducing people to apply for treatment;" and

WHEREAS, Continued violation of the legislative intent to protect the public health weakens the public's confidence in the Legislature and the title "Doctor," confuses the public in the selection of competent health care, decreases respect for the law and sound, scientific health practice; therefore be it

Resolved, That the State Medical Society of Wisconsin make a strong appeal to the Wisconsin Legislature and state and local law enforcement offices for immediate and full enforcement of the statutes with regard to the proper use of the title "Doctor" by all who treat the sick; and be it further

Resolved, That the State Medical Society of Wisconsin, in the interests of providing sound health guidance for the citizens of this state, challenge the improper use of the title "Doctor" wherever it occurs by publicly exposing such misleading and dangerous practices; and be it further

Resolved, That this House of Delegates of the State Medical Society of Wisconsin authorize the preparation of a statement, in manner approved by the Council, which contains the official definition of "chiropractic" and the limitations upon its practitioners in that the law of Wisconsin denies them:

The right to use the title "doctor"
The right to sign vital statistics records including death certificates
The right to use electrotherapy
Any privilege under the quarantine laws
Treatment of the workmen's compensation case
Treatment of public assistance cases
The use of drugs and medicines in the rendition of chiropractic treatment
The use of electrocoagulation procedures
The right to puncture the skin or take blood samples
The right to suggest or advise a course of diet or corrective dietary habits
The right to render psychosomatic counselling to patients
The right to make a medical diagnosis
The use of such instruments as colonic irrigators, diathermy, plasmatic, short wave, radionics, or ultrasonic;

and be it finally

Resolved, That such statement be circulated to all law enforcement officers of this state, educators and others to the end that the public be educated as to the strict limitations upon these practitioners and not be misled as to their qualifications as the result of a vast amount of erroneous information being distributed by them.

ANNUAL MEETING HIGHLIGHT . . .

Dr. Elizabeth Comstock Given Council Award

THE HIGHEST HONOR bestowed by the State Medical Society is the Council Award, being presented above to Dr. Elizabeth Comstock, Arcadia, by Dr. James C. Fox, La Crosse. The event was a highlight of the annual dinner in Milwaukee May 3.

Dr. Elizabeth Comstock, Arcadia, was presented the Council Award, highest honor given by the State Medical Society of Wisconsin, at the annual dinner of the Society in Milwaukee May 3.

The award is granted to persons who have served the science of medicine, their fellow physicians and the public with outstanding distinction.

Doctor Comstock, a general practitioner in Arcadia since 1923, is the second woman to be so honored.

SMS LIFE INSURANCE

Any physician who joined the State Medical Society since June 15, 1959, and is under age 44½, is now eligible for entering the SMS life insurance program without a medical examination if he applies before June 15.

This is the life insurance program made available to state society members through The Bankers' Life Insurance Company. For information see any local Bankers' Life agent or write to State Medical Society, Box 1109, Madison, for an application form.

Council Approves Two Studies, Lists Awards And Appointments

Meeting in Milwaukee, prior to the annual meeting, the Council took the following actions, in addition to those approved by the House of Delegates:

Crash Injury Study

State Medical Society participation in a study of deaths and injuries in Wisconsin rural auto accidents was approved. The two-year study, starting about July 1, will depend on physicians to supply information on extent and severity of injuries. Eventual aim—to bring about auto re-design to provide a safer "package" for passengers.

Release from Custody

Referred to its Division on State Departments a study of proper mechanisms for the release from custody of persons adjudged insane, with a suggestion for a joint meeting with representatives of the State Bar of Wisconsin on the problem. (See editorial, "Social Dilemma", March, 1961, *Wisconsin Medical Journal.)*

Hospital Awards

Announced selection of St. Joseph's Memorial Hospital, Hillsboro, and St. Luke's Memorial Hospital, Racine, as recipients of the 1961 Hospital Awards.

Appointments

Reappointed Dr. T. W. Tormey, Jr., Madison, chairman of its Commission on State Departments with the following Division chairmen:

- AGING—Dr. A. M. Hutter, Fond du Lac
- CHEST DISEASES—Dr. H. A. Anderson, Stevens Point
- HANDICAPPED CHILDREN—Dr. J. W. Nellen, Green Bay
- NERVOUS & MENTAL DISEASES—Dr. E. D. Schwade, Milwaukee
- PUBLIC ASSISTANCE—Dr. H. W. Carey, Lancaster
- REHABILITATION—Dr. Ray Piaskoski, Milwaukee
- SAFE TRANSPORTATION—Dr. Dayton Hinke, Richland Center
- SCHOOL HEALTH—Dr. L. M. Simonson, Sheboygan
- VISUAL & HEARING DEFECTS—Dr. Meyer S. Fox, Milwaukee
- MATERNAL & CHILD WELFARE—Dr. John Evrard, Milwaukee

the Wisconsin Medical Journal

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President's Message to the House of Delegates

By LEIF H. LOKVAM, M. D.
Kenosha, Wisconsin

ALTHOUGH TODAY in our land we are blessed with unparalleled success and achievement, we suffer from overwhelming anxiety about personal security. This growing emphasis by some upon security at any cost, usually that security which is based upon tax supported measures, is becoming the idolatrous golden calf of our time. Will this worship make the American citizen a stronger and better person, better able to serve his country and society? Or will it weaken his physical and moral fiber so that he is of little value to himself or society? Historically, the latter has tended to become man's disastrous end.

One of the many remedies for this anxiety, which is of great concern to many other than physicians, is the Federal plan of medical service presented under the umbrella of the Social Security System.

This plan, though readily welcome to some, is abhorrent to others, both in and out of the medical profession, who regard it as philosophically fallacious and economically unsound. We will continue to resist those who are more concerned with the politics of expediency than in the advancement of good medical care.

As physicians we have attained stature and have been given respect by those to whom we minister—our patients. But at the same time, we are soundly spanked by carping critics and testy TV editorializing as witness the Columbia Broadcasting System's strongly biased presentation of recent weeks. This year of 1961 will be a crucial year in the history of the medical profession and our entire social structure.

The effect of Federal control of medical

Presented before the House of Delegates at the One Hundred Twentieth Annual Meeting of the State Medical Society, May 1, 1961, Milwaukee.

services will ultimately extend far beyond the immediate limitations of the care of the sick. Historically, it has been demonstrated that it inevitably touches every socio-economic area. A judgment must be made about the future of medical care in the United States. Should we not have a strong voice in this decision? As I take office during this controversy I call upon all physicians to accept maturely their individual and collective responsibilities, even sacrificing personal security, and thereby obviating any imagined need for the Federal government to assume some of our rightful responsibilities.

Our care of the sick, our attempt to relieve suffering, is based upon an age long and painful struggle over the tortuous path from total ignorance and lack of compassion to present day enlightenment and concern. With the first response to someone's cry of pain and anguish in the dark jungle of our beginning, the first ministry to the suffering had its origin. No artifice of governmental agency or bureaucratic directive initiated that human response. This direct, immediate, and personal action sustains excellent, humane medical care today. It is manifested in the many voluntary organizations, whose very reason for being is to aid those in need. It exalts those who contribute and participate in this work. It is manifested in the physician's contribution, individually and collectively in unmeasured free time, skill and service.

To us much has been given, and in a like manner much is expected in return. The best means for us as physicians to offer the kind of medical program the sick need and deserve, the kind to which we all aspire, is to carry on unselfish service and devotion to the sick. This devotion to which I refer may be realized by continued service to the medically indigent, by supporting and implementing the Kerr-Mills Act, by continued cooperation with all voluntary health plans, by a strong, unified medical-surgical plan . . . unmistakably clear in its organization and fulfilling its purpose.

In other ways, it may be realized by the strengthening of our medical schools and faculties, by the recruitment of fine young men and women for medical training.

The fine beginnings of medical research in Wisconsin should be given constant stimulus. Private funds and endowment for this purpose should be encouraged to prevent total Federal domination of such research with unlimited tax funds. Such funds often are used without purpose in projects unrealistic in conception.

Since we are citizens first and doctors second, we must accept other responsibilities to society. We must be leaders in the great work of civilian defense. This program is increasingly urgent when we are suddenly reminded that the Communist beach-head now lies 90 miles off our shores, with rockets and nuclear weapons and all that they threaten.

If we are to survive this grave threat, we must begin to not only think of this problem, but take immediate and direct action by installing bomb shelters wherever possible in homes and in public buildings.

We must participate in civic affairs, and be willing to serve on school boards and city councils, to take part in community service and religious service. We must be active in our county medical societies, to show through them strong support and unity in our state organization, and thereby to strengthen the American Medical Association.

In these days of great social and spiritual turbulence, we are in the midst of peculiar contradictions. We encourage and assist the nations of the world, both old and new, to gird themselves as free men, to stand firm in the bright light of day against governmental autocracy or enemy invasion. But at the same time, many citizens would supinely permit our government to shelter us ignobly under the cloak of Federal control. Are we to forsake for ourselves the cherished freedom we encourage for others? The fierce demands of freedom must be realized and acted upon if we are to preserve that freedom. We must not allow ourselves to be distracted from our proper duties and responsibilities by socialistic brush fires. Far better to keep the torch of liberty burning brighter by our continued day by day service.

Only in this manner can we as a nation have the proper relationship to organized government, where it properly exists to serve the people without destroying the individual. In this climate there has been unparalleled growth since our nation's beginning. In this climate of freedom we will continue this growth, and thereby more ably serve our fellow man. Join with me and all others who have respect for the past, and hope for tomorrow, to have conviction in our present ideals.

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723 58th Street.

Leontiasis Ossea

By PAUL M. KROENING, Capt., MC

San Francisco, California

LEONTIASIS OSSEA is a rare disease of the skeletal system. In the past it has been referred to as "hyperostosis of the skull," "megalocephaly," "hyperostosis des os de la tete," and "diffuse osteomata." It was first discovered by Malpighi in 1697 but was not called leontiasis ossea until 1864 when Virchow described it in detail.[1] This name was selected due to the resemblance of the patient's face in the latter stages of the disease to that of a lion (broadening of the nose, protrusion of the jaw, and bossing of the forehead).[2]

The etiology of leontiasis ossea is unknown. Virchow believed that it was due to inflammation which results in sclerosis of the involved bones. Others have incriminated hyperparathyroidism and multiple osteomata.[3] The most popular causes considered now are fibrous dysplasia and Paget's disease.[3-6] Those that favor fibrous dysplasia have noted multiple sites of involvement and findings consistent with Albright's syndrome (polyostotic fibrous dysplasia, precocious puberty in females and cutaneous pigmentation). Others support Paget's disease because of its progressive nature and an elevated alkaline phosphatase reaction. They claim it is detected earlier than the usual case of Paget's disease (fourth decade) because of local involvement which produces symptoms that direct attention to it.

Leontiasis ossea has been found more often in females. It is rarely detected in infants.[7] One third of the cases have unilateral involvement only.[3] It has been classified as follows: (1) Unilateral hyperostosis of the skull. (a) One-half of the sphenoid bone. (b) Temporal bone. (2) Unilateral or bilateral hyperostosis of the skull. (a) Limited to the jaw, especially the maxilla. (b) Parietal bones.[8] Leontiasis ossea begins in the facial bones as above but it may progress, and in the most advanced cases it may result in complete involvement of the skull. The disease may be arrested at any stage and often does not cross over sutures. Rarely it involves other bones of the body.[1,9]

Leontiasis ossea is characterized clinically by the development of painless swellings, over the involved facial bones, which usually progress slowly but may spread rapidly. Pain occurs when local nerves are trapped by the expanding bone. Uneven enlargement of bony structures may produce proptosis, nasal septum deviation, or malocclusion.

The pathologic changes resemble those of osteitis deformans (Paget's disease) or osteitis fibrosa cystica.[9] There may be Pagetoid lamination with osteoid tissue and lacunae formation or multiple cystic areas.[10] Periosteal new bone formation has been described.[2] The blood calcium and phosphorus levels are not altered but the alkaline phosphatase may be elevated, especially in far advanced cases.[3]

The diagnosis of leontiasis ossea can be made roentgenologically before clinical symptoms develop. Characteristically there is seen deforming enlargement of the bones involved with narrowing of their medullary portions and secondary narrowing of the fissures, foramina, orbits, and sinuses.[9] The calvarium may exceed 5 cm. in thickness. Often the process stops at a suture line.[11]

The differential diagnosis includes Paget's disease, fibrous dysplasia, hyperostosis cranii, hyperparathyroidism, acromegaly, infectious osteitis, cephalhematoma, and neoplasms.[1,12,13] Paget's disease is most commonly seen in older persons. It characteristically involves multiple bones, has rounded areas of porosis and sclerosis, thickened trabeculations, and a markedly elevated alkaline phosphatase. Fibrous dysplasia may show polyostotic involvement and Albright's syndrome. Hyperostosis cranii, hyperparathyroidism, and acromegaly have specific radiographic appearances or often clinical findings of endocrine dysfunction. Infectious osteitis and trauma may occur anywhere but usually

From the Radiology Service, Letterman General Hospital, San Francisco.

Fig. 1—Demonstration of exophoria when this patient who has leontiasis ossea converges his eyes. Note that the left eye is lower than the right.

demonstrate sequestra formation, periosteal reaction, or have a significant clinical history and hematologic findings. Neoplasms may be the most difficult to differentiate radiographically but their clinical course is often specific.

The treatment of leontiasis ossea is symptomatic. Local surgical decompression may be necessary to save a proptosing eye. The prognosis depends upon the progression of this process. There have been two cases that reportedly developed into fibrosarcoma.[3]

Case Report

This 10-year-old Caucasian boy was born in 1949 after a normal pregnancy, the fourth of five children. It was noted at this time that his left eye was slightly lower than his right eye, but was otherwise normal. His forehead was quite prominent and a large birthmark was present on his right flank. He developed normally, had the usual childhood diseases including chickenpox, red measles, rubella, and occasional upper respiratory infections but experienced no trauma of significance until April, 1958, when he was kicked in the left forehead while engaging in a friendly scuffle. The skin was not broken, but the area swelled. At this time his parents became aware that his left supraorbital area was more prominent than the right. In September, 1959, he was advised by his teacher to procure eyeglasses, and it was discovered that he had an error of refraction and convergent diplopia. He denied photophobia, dizziness, or headaches. In August, 1960, he was admitted to an army hospital for evaluation of his facial asymmetry and visual disturbance. Because his left eye appeared proptotic he was thought to have hyperthyroidism, so he was referred to our hospital for further study.

Examination at this institution revealed a healthy young male who was quite shy and conscious of his deformity. His left supraorbital area was prominent but not tender, and his left eye appeared proptotic and did not fully coordinate with his right eye. A large area of brown pigmentation was found on the right flank. There were no other significant clinical findings.

Laboratory studies revealed a normal complete blood count, urinalysis, protein-bound iodine, and blood calcium and phosphorus levels. His alkaline phosphatase was elevated on two examinations (11.3 Shinowara-Jones units and 14.3 Bodansky units—both have 2 to 9 units normal range).

An ophthalmologic consultation disclosed his vision to be correctable to 20/20 bilaterally, a slight exophoria in his left eye which was probably due to his error of refraction, and his left eye was 6 mm. lower than his right eye. His extraocular muscles, visual fields, fundi, and exophthalmometer readings were normal. The proptosis was only apparent and due to the deformity of his left orbit (Fig. 1).

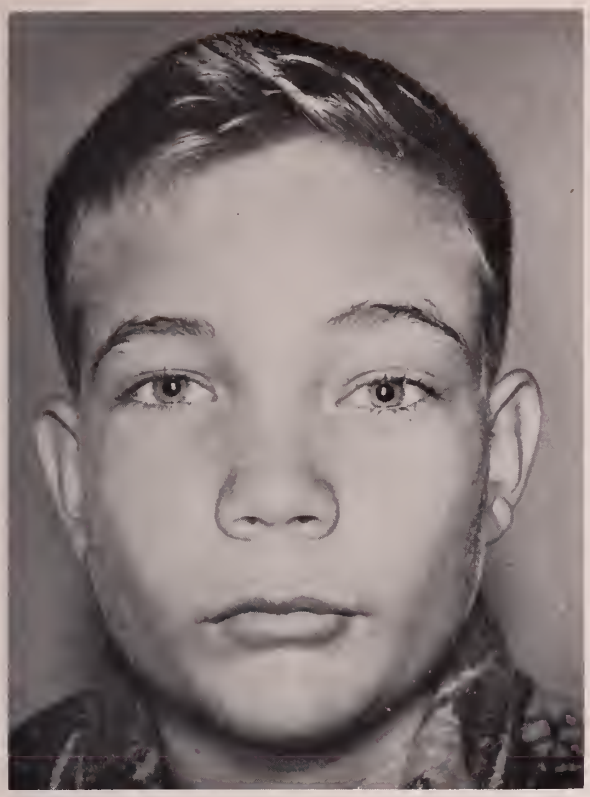
On Feb. 5, 1959, radiographic studies of the skull revealed a dense floor of the anterior fossa and the left orbit smaller than the right. A skull series taken at this hospital in August, 1960, revealed a dense sclerotic process involving the left supraorbital portion of the frontal bone and the left greater and lesser sphenoid wings, resulting in thickening of these bones. The left orbit was smaller than the right (both depth and circumference), and the lateral portion of the left superior orbital fissure might be closed (Fig. 2). (Note: This process did not cross the zygomaticofrontal suture.) The optic foramina were normal. The remainder of the skull and the rest of the skeletal system were not involved with this process.

Discussion

The radiographic and clinical findings of the case presented are classically those of leontiasis ossea. The left supraorbital area of the frontal bone and the left half of the sphenoid are the only osseous structures involved, which has resulted in disfigurement of the left superior facial structures including prominence of his left eye. The nerves in this area have not been affected up to this time, but the psychological effect of this deformity has already become manifest.

Evaluation of the findings since birth lead to the conclusion that this boy was born with leontiasis ossea. This did not arouse parental concern until his injury. Since that time his ocular dysfunctions probably have been due to his progressive error of refraction. If this is the situation, his disease may be arrested, or progressing very slowly. Should his left eye become truly proptotic it will be necessary to perform a surgical decompression of the left orbit to save the eye.

One of the most interesting features in this case is the finding of one major diagnostic criterion for each of the two most commonly



(a)

(b)

(c)

(d)

Fig. 2 (a-d)—Comparison of photographs (a and c) and radiographs (b and d) of this patient who has leontiasis ossea. The left supraorbital area of the frontal bone and the left half of the sphenoid bone are involved. Note that the process does not cross the left zygomaticofrontal suture (b).

accepted etiologic considerations of leontiasis ossea. He has a large pigmentation on his abdomen which supports polyostotic fibrous dysplasia, and an elevated alkaline phosphatase as found in Paget's disease. One can only conclude that leontiasis ossea still remains a mystery to medical science.

Summary

Leontiasis ossea is a rare disease of the skeletal system. The radiographic appearance is important in establishing the diagnosis. The etiology is uncertain and the treatment is symptomatic.

A case is presented. The disease was present at birth but may be progressive. The diagnostic findings failed to reveal the cause of this disease.

Addendum

A follow-up examination on Dec. 27, 1960, revealed no change in the patient's clinical or radiographic appearance.

ACKNOWLEDGMENTS: The author is indebted to Mrs. Elizabeth Thompson and SP5 Helen Sullivan for their help in preparing this article.

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SOME UNUSUAL FORMS OF FAT NECROSIS IN SURGICAL PATIENTS

PAUL L. WOLF, M.D., Department of Pathology, Wayne State University Affiliated Hospitals, Detroit. Abstract from *Journal of the Michigan State Medical Society* 59:1564 (Oct.) 1960.

Extra-Abdominal Subcutaneous Fat Necrosis.—Necrosis of abdominal fat occurs in both interstitial pancreatitis and hemorrhagic necrosis of the pancreas. It is generally agreed that the factor common to necrosis of abdominal fat is the release of activated enzymes into the abdominal tissues. Pancreatic lipase is the important enzyme in this respect. It is postulated that rupture of the finer ducts and acini is essential for the release of enzymes. Although ligation or obstruction of the pancreatic duct does not cause pancreatic necrosis, necrosis may occur if, in addition, the gland is stimulated to secrete actively.

Fat necrosis characteristically occurs in small patches. It may be seen in the pancreas as a concomitant of hemorrhagic necrosis. It may also occur as a result of traumatic injuries of the pancreas. Fat necrosis may be found in the omentum, mesentery, pancreatic fat and retroperitoneal fat tissue. In fat necrosis fatty acids and glycerol are liberated, and while glycerol is apparently absorbed, the fatty acids combine with calcium to form soaps.

Extra-abdominal fat necrosis may be due to lipase transmitted through lymphatics throughout the body. This is a rare entity. In the few cases recorded in the last few years, these lesions have been associated with acute pancreatitis, carcinoma of the pancreas and portal cirrhosis associated with pancreatitis.

A case of carcinoma of the pancreas and associated acute pancreatitis with extra-abdominal subcutaneous fat necrosis was recently observed at Detroit Memorial Hospital and is herewith reported.

Sclerema Neonatorum.—A case of nodular sclerema neonatorum which is subcutaneous fat necrosis of the newborn was recently observed at Receiving Hospital. Two types of sclerema neonatorum are nodular and generalized. The generalized form produces hard, waxlike skin. Death occurs within a week. However, the nodular form is self limited and the disease spontaneously disappears. The nodular masses are symmetrical and bilateral. Surgery should not be employed.

In nodular sclerema neonatorum, one observes deep-seated indurated areas in the subcutaneous fat. Histologic findings include degeneration, necrosis and crystallization of the subcutaneous fat together with an inflammatory reaction and fibrosis. It is possible that the disease is due to a delay in the maturation of the fat producing low oleic acid content which disposes to solidification.

Fatal Disseminated Varicella in Adults; Report of a Case and Review of the Literature

By ROYAL ROTTER, M.D., and JAMES D. COLLINS, M.D.

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THAT VARICELLA in adults can be a serious and even fatal disease is becoming a well-established fact. The virus of chickenpox can produce lesions in many organs, but pulmonary involvement is particularly serious and accounts for a significant proportion of the mortality. The gastrointestinal tract, kidneys, brain, lymph nodes, spleen, adrenals, liver, and other organs may also be involved by the disease process.

In 1942, Waring et al.[1] described 2 cases of primary varicella pneumonia, one of which ended fatally. Since that time there have been numerous case reports of disseminated varicella, bringing the total reported number of deaths in adults to 21. The mortality rate in patients with disseminated chickenpox is hard to determine, but it has been estimated at between 10 and 30%.[2] In this report we describe an additional fatal case of disseminated varicella and review the reported deaths in adults from this disease during the past 18 years.

Case Report

This 32-year-old Hindu man from India, a research assistant, was admitted to the hospital on June 13, 1960, with a chief complaint of cough. He first became ill on June 8, 1960, at which time he had developed malaise and weakness, and had noted a few papules and vesicles on his chest and face. He stated that he had been exposed to chickenpox in his 3½-year-old daughter two weeks previously and that he had never had this illness before. He further complained of fever and chilliness and sharp shooting pains in his chest and abdomen that were aggravated by motion of his trunk and by deep breathing. He was examined at home and a diagnosis of chickenpox was made. The recommended treatment consisted of rest, forced fluids, salicylates, and codeine. During the ensuing two days, the eruption spread rapidly to involve his entire trunk, back, face, scalp and all mucous membranes. The lesions were primarily vesicular but there were some pustules and crusts present. The pain in his chest and abdomen increased, and codeine was required every three hours for relief of pain. He developed anorexia and increasing weakness and was able to take only liquid nutrition. On June 12, 1960, the patient developed a deep persistent cough that kept him awake throughout the night. It was productive of pink, mucoid sputum. The patient was hospitalized the following day, five days after the onset of his illness.

The patient had dizziness associated with a generalized weakness and some swelling of his eyelids for about three days prior to admission. He had mumps in childhood, and had been immunized to typhoid, cholera and smallpox five years previously, when he came to the United States for the first time. His father died of senility and his mother was living and well. He had four living siblings, one of whom had bronchial asthma. Another died in India at age 20 of typhoid fever. The patient was employed as a cancer research associate.

The patient was a well-developed, well-nourished Indian man, 32 years old, who was acutely ill. He had tachypnea with a respiratory rate of 28 per minute, and he was using the accessory muscles of respiration. There was dilatation of the alae nasae, and the patient had subcyanosis of the lips and fingernails. His temperature was 100.4 F. orally (37.9 C.), his pulse rate was 128 per minute, and his blood pressure was 132/58. The skin of his entire trunk, face and scalp was covered with a papulovesicular eruption along with some pustules and crusts (Fig. 1). There were a few papules and vesicles on his thighs, but the palms of his hands and the soles of his feet were not involved. There was moderate edema of the eyelids but no lesions of the conjunctivae. Papules and vesicles were present in both ear canals, on the nasal mucous membrane, the oral mucous membrane, the gingivae, the posterior pharnyx, and the soft palate. His skin was warm and moist. There was neither nuchal rigidity nor other meningeal signs. The heart was normal in size to percussion and the heart rate was 128 per minute. No murmurs were audible. Lungs expanded equally, but his chest was filled with crepitant râles bilaterally both anteriorly and posteriorly. Breath sounds were depressed. His abdomen was somewhat distended and the liver was thought to be palpable about 3 cm. below the right costal margin. Neurologic examination was negative.

From the Department of Medicine and Pathology, Madison General Hospital.

Fig. 1—Face of patient showing extensive papules, vesicles, pustules and crusts of varicella.

Fig. 2—Chest roentgenogram, bedside technique, showing extensive bilateral bronchopneumonia.

The patient's urine specific gravity was 1.020. There was 1+ albumin, an occasional pus cell, and 1 to 3 granular casts per high-power field. His hemoglobin on admission was 17 gm. per 100 ml. and hematocrit 50%. The white blood cell count was 8,900 per cubic ml. and the differential count revealed 49% segmented neutrophils, 22% band cells, 26% lymphocytes, and 3% monocytes. Platelets were adequate in number, and the sedimentation rate was 4 mm. in 60 minutes. A repeat blood count on the day of the patient's death revealed no essential change except for the presence of an occasional Türk irritation cell. Blood Wassermann was negative and cold agglutinins were negative. Blood urea nitrogen was 20.2 mg. per 100 ml. and blood sugar was 148 mg. per 100 ml. A repeat fasting blood sugar was 132 mg. per 100 ml. (The patient was receiving dextrose intravenously.) Thymol turbidity was 5.5 units and total serum protein was 6.1 gm. per 100 ml. (albumin 3.8 and globulin 2.3 gm. per 100 ml.). Prothrombin time was 13.8 seconds with a control of 12 seconds. Two sputum smears were negative for acid-fast bacilli but there was a light growth of pneumococci. Chest x-ray on admission revealed a bilateral, confluent, extensive bronchopneumonia involving all lobes of the lungs (Fig. 2). The heart size appeared to be normal.

The patient was treated at bed rest with oxygen at 6 liters per minute, meperidine, and phenobarbital (Luminal) sodium parenterally. He was also given chloramphenicol, 1 gm. intramuscularly every six hours, and hydrocortisone by slow intravenous drip in a dosage of 200 mg. in a solution of 1,000 cc. of 5% dextrose in normal saline. In addition he was given 100 mg. of hydrocortisone intramuscularly. Despite this the patient experienced increasing respiratory embarrassment. His temperature rose to 101.8 F. (38.7 C.) orally, and his lungs remained filled with râles. On the morning of June 14, the patient lapsed into coma. Four limb tourniquets were applied, and 100 mg. of hydrocortisone was administered intravenously. The patient was also given lanatoside C, 0.4 mg. intravenously, and oxygen by positive pressure. Following this procedure there was some clearing of the left lung, and the patient became alert and recognized his wife and surroundings. Throughout the remainder of that day, oxygen was continued by positive pressure and interrupted only briefly to give the patient some oral liquids. Early in the morning of June 15, 1960, despite the continued use of positive pressure oxygen, the patient became delirious, unmanageable and died.

Autopsy studies showed the body to be that of a well-nourished, well-developed Indian man. The skin, predominantly of the trunk and head, was covered with a papulovesicular eruption and some pustules. In some areas the lesions were confluent with a purplish discoloration. These lesions varied in size from 2 to 4 mm. The right and left pleural spaces contained 850 and 450 cc. of cloudy serous fluid, respectively. The lungs weighed 1,085 gm. The pleural surfaces were glistening and studded with umbilicated lesions similar to the ones described on the skin. The lungs were quite firm to palpation; and, on sectioning, a marked amount of blood and frothy fluid exuded from the sectioned surface. The sectioned surface of both lungs contained numerous hemorrhagic nodular areas of consolidation 3 to 5 mm. in diameter (Fig. 3). The lower bronchial tree was filled with a frothy bubbly fluid.

The liver weighed 1,820 gm. The surfaces were glistening and studded with lesions similar to those

Fig. 3—Cut surface of lung showing numerous hemorrhagic nodulations.

Fig. 4—Two sections through cerebral hemispheres showing hemorrhagic areas throughout the white matter with greatest prominence in the thalamic nuclei. No varicella lesions were demonstrated in the brain.

on the skin and pleura. On section, the parenchyma had similar lesions diffusely scattered throughout. The spleen weighed 230 gm. The surface was somewhat roughened due to the presence of numerous lesions like those on the skin. On the sectioned surface, focal areas of necrosis 2 to 3 mm. in diameter were identified. The mucosa of the stomach showed multiple areas of superficial ulceration 3 to 5 mm. in diameter. The brain weighed 1,325 gm. The cerebral hemispheres were symmetrical with prominence of the surface vasculature and diffuse petechial hemorrhages throughout the hemispheres, including the thalamic nuclei (Fig. 4). Sections of the cerebellum, pons and medulla revealed moderate vascular engorgement but no hemorrhages.

Microscopic sections of the vesicular lesions in the skin revealed reticulated septa, formed by degeneration and compression of cells which enclosed loculi of serum and exudate. At the base and margins of the lesions giant cells were found. The dermis at the base of the vesicles was edematous, hyperemic and infiltrated with moderately dense collections of lymphocytes and histiocytes. Sections of the lung revealed marked edema and congestion with focal areas of necrosis scattered throughout. Many of the alveoli contained segmented neutrophils with an exudate of red blood cells, fibrin, and mononuclear phagocytic cells. In some areas desquamated alveolar septal cells were found. Lining many of the dilated alveolar spaces was an acellular pink-staining membrane-like structure similar to the one found in hyaline membrane disease of the newborn (Fig. 5).

Focal areas of necrosis were scattered throughout the spleen. The nuclei were fragmented with a loss of cellular morphology; and an infiltration of segmented neutrophils, lymphocytes and mononuclear cells surrounded these areas. Many of the sinusoids were obliterated and diffusely infiltrated with segmented neutrophils. The parenchyma was moderately edematous. In the liver focal areas of necrosis were noted with the loss of cellular architecture (Fig. 6). There was much nuclear debris; and there were numerous neutrophils, lympocytes and macrophages in these areas. The tiny areas of mucosal ulcerations

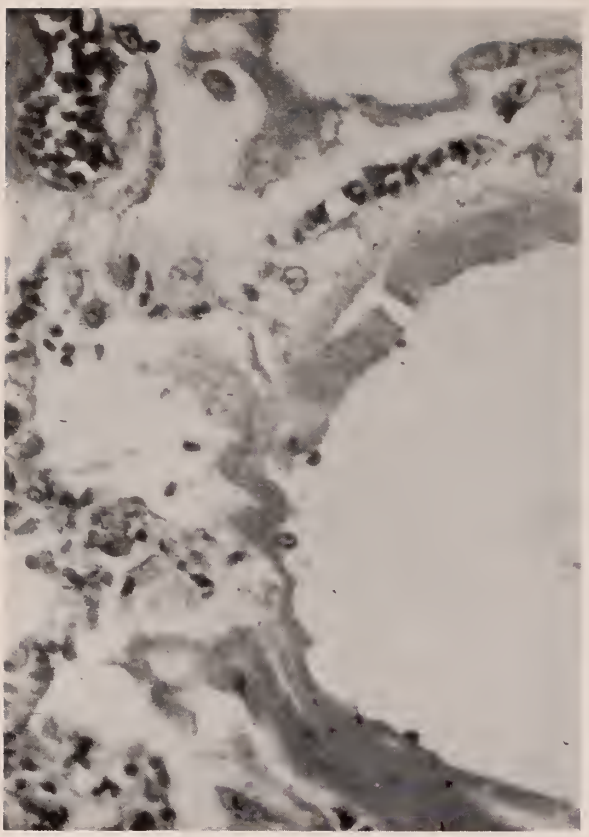

Fig. 5.—Microscopic section of the long showing dilated alveolar space lined with membrane-like structure similar to hyaline membrane disease of newborn, (X500).

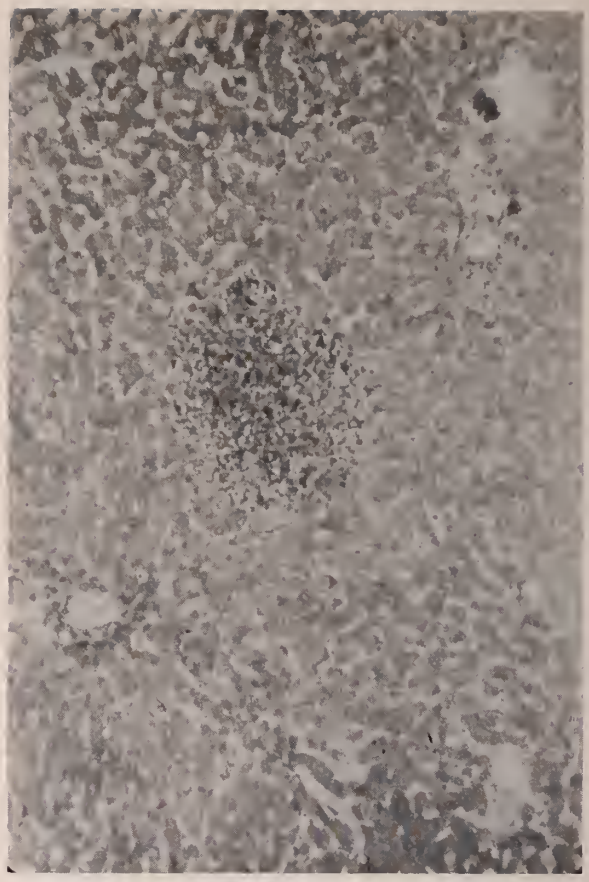

Fig. 6—Microscopic section of the liver showing focal area of necrosis, (X150).

in the stomach revealed loss of the superficial mucosal coat with a base composed of fibrin, necrotic cells, macrophages and segmented neutrophils. The cerebral and thalamic structures showed diffuse petechial hemorrhages. No evidence of encephalitis or meningitis could be found. The cerebellum and pons were unremarkable. No inclusions could be identified in any of the sections. Coxsackie, polio and ECHO virus studies on the tissues were all negative.

Comment

The clinical features of the 22 adults who died of disseminated varicella are very similar (Table 1). The average was 33.9 years with variations from 19 to 71. Most of the group were in the third, fourth, or fifth decade of life. The sexes were almost equally represented. The majority of the patients were Caucasian, although there was one Negro, one Filipino, and one Indian. In almost every instance the source of infection was the patient's own child; however, the patient in Case 14 was an intern who contacted the illness from one of his associates, and in Case 21 the patient's only known contact was a patient with herpes zoster. Five of the women were pregnant and three others had underlying lymphoid disease. Almost always the patients presented a history of prior smallpox vaccination but they had never previously had chickenpox.

The typical vesiculopapular skin rash of varicella appeared approximately 14 to 16 days after exposure, and it was usually severe. Evidence of systemic involvement appeared about two or three days following the eruption. Unusually severe pleural pain occurred in some instances and was particularly severe in this patient. Persistent cough with hemoptysis, dyspnea, tachypnea, and cyanosis developed rapidly; and there was frequently a high fever. Coma preceded death in several instances. Physical examination of the lungs was nonrevealing early; but diffuse scattered râles in both lung fields commonly developed, and the accessory muscles of respiration were brought into play.

Laboratory studies, when reported, disclosed a white blood cell count that was nor-

TABLE 1—*Clinical Features of 22 Adults Who Died of Disseminated Varicella*

Source	Sex	Race*	Age	Source of Infection	Clinical Manifestations	X-Ray Findings	Treatment	Autopsy
1. Waring et al.[1] 1942	—	—	30					Severe lobular pneumonia.
2. Waring et al.[1] 1942	M	W	40	Child	Coma, varicella rash, cyanosis dyspnea, hemoptysis. Died 5 days after admission.	Widespread mottling throughout.	Oxygen tent, intravenous fluids, sulfonamide.	Acute toxic encephalitis, acute toxic nephrosis and lobular pneumonia.
3. Claudy[3] 1947	F	W	32	Child	Cough, abdominal pain, varicella rash, chest tightness with dyspnea and cyanosis.	Homogeneous density in the lower one-third of left lobe. Diffuse bronchopneumonia-type infiltration.	Vitamin K, sulfonamide, convalescent serum, digitalis.	Visceral varicella involving spleen, liver, lung and pleura. Typical varicella pneumonia.
4. Frank[4] 1950	F	W	34	Child	Died shortly after admission. Four days of illness with hemoptysis and dyspnea.	—	Penicillin	Varicella pneumonia. Lesions also on surface of esophagus.
5. Eisenbud[5] 1952	F	W	71	Unknown	Generalized dermatitis 10 days prior to admission. Developed cough productive of thick yellow sputum. Dyspnea and cyanosis.	—	Oxygen	Visceral varicella of lungs, spleen, adrenal and tracheobronchial lymph nodes. Also had Boeck's sarcoid. Typical varicella pneumonia.
6. Hackel[6] 1953	F	—	32	Unknown	Five days' duration of disease. Died 14 hours after therapy started. Six months pregnant.	—	Oral sulfonamide, penicillin and chlortetracycline intravenously, penicillin and streptomycin intramuscularly.	Varicella bronchopneumonia. Myocarditis.
7. Lander[7] 1955	M	—	36	Child	Admitted cyanosed and comatose. Stertorous breathing. Developed flaccid paralysis of extremities.	—	Pooled serum, chlortetracycline, procaine penicillin, streptomycin, oxygen.	Varicella lesions of lungs. Petechial hemorrhages in the heart. Widespread petechial hemorrhages of white matter of brain. Microscopic studies showed demyelination and fibrinoid necrosis of cerebral vessels.
8. Fitz et al[8] 1956	M	W	35	Child	Rash 4 days prior to death.	—	—	Varicella pneumonitis and myocarditis.
9. Fitz et al.[8] 1956	M	W	29	Child	Cough and dyspnea. Died at home.	—	Sulfonamide at home.	Varicella pneumonitis. Visceral varicella with involvement of pleura, esophagus and pharynx.
10. Fitz et al.[8] 1956	M	W	42	Child	Cough, hemoptysis, dyspnea and cyanosis.	—	Penicillin, tetracycline, oxygen and digitalis.	Varicella lesions of lung, liver, kidney and spleen. Typical varicella pneumonia.
11. Rizk et al.[9] 1956	M	W	41	Unknown	Previous diagnosis of lymphoma. Dyspnea and cyanosis.	Widespread mottling throughout.	Penicillin, tetracycline.	Varicella lesions of epiglottis, larynx and trachea. Typical varicella pneumonitis. Toxic hepatitis. Toxic splenitis. Severe nephritis. Lesions of gastrointestinal tract. Lymphosarcoma.
12. McLachlan[10] 1957	F	—	35	Unknown	Cyanosis and dyspnea. Shock; generalized crepitations over both lungs.	—	Oxygen, suprarenal cortex (Eucortone), antibiotics.	Varicella lesions of palate, tongue, epiglottis and vagina. Also lesions of esophagus, trachea and main bronchi. Varicella pneumonitis.
13. Nicolaides[11] 1957	M	W	34	Child	Cyanosis and coma.	X-rays suggestive of extensive bronchopneumonia.	Penicillin, sulfonamide, chlortetracycline.	Encephalitis of varicella. Typical varicella pneumonia.
14. Trimble[12] 1957	M	F	27	Associate intern	—	—	—	—
15. Krugman et al.[13] 1957	F	N	26	Unknown	Fever and varicella rash. Dyspnea and hemoptysis. Generalized rash.	Extensive nodular infiltration throughout both lungs.	Oxygen tent, tetracycline.	Varicella lesions of skin, lungs, trachea, vaginal mucosa and liver.
16. Krugman et al.[13] 1957	M	—	44	Unknown	By personal communication to Krugman.			Lesions in skin, lungs and liver.
17. Fish[14] 1960	F	—	24	Child	Cough, cyanosis, hemoptysis and cramping lower abdominal pains. Spontaneous abortion.	Extensive diffuse bilateral pneumonitis.	Oxygen, tetracycline.	Varicella lesions of esophagus, pleura, lungs, spleen, liver and bladder. Pneumonitis. Toxic nephrosis.
18. Fish[14] 1960	F	—	19	Child	Symptoms same as above. Spontaneous abortion.	Bilateral diffuse extensive pneumonitis.	Blood transfusion, levarterenol bitartrate, penicillin, tetracycline, oleandomycin.	Focal glomerulonephritis. Diffuse bilateral interstitial pneumonitis.

continued on next page

TABLE 1—*Clinical Features of 22 Adults Who Died of Disseminated Varicella—Continued*

Source	Sex	Race*	Age	Source of Infection	Clinical Manifestations	X-Ray Findings	Treatment	Autopsy
19. Fish[14] 1960	F	—	26	Child	Developed varicella with treatment at home. Pregnant.	———	Oleandomycin, tetracycline, novobiocin.	No autopsy.
20. Fish[14] 1960	F	—	23	Child	Developed typical signs and symptoms of varicella. Spontaneous abortion.	Diffuse bilateral mottled pulmonary infiltration without consolidation.	Humidified positive pressure oxygen, tetracycline, cortisone, erythromycin.	No autopsy.
21. Johnson & Nelson[15] 1960	F	—	34	Patient with herpes zoster	Previously diagnosed as Hodgkin's disease. Dyspnea and cyanosis. Consolidation of right lung.	———	———	Varicella lesions of skin and esophagus. Both lungs showed bronchopneumonia consolidation. Hodgkin's disease of spleen.
22. Rotter & Collins	M	I	32	Child	(see text)	(see text)	(see text)	(see text)

* W—white, F—Filipino, N—Negro, I—Indian.

mal or slightly elevated. In the patient reported here, there was a marked left shift with a terminal appearance of Türk irritation cells. The sedimentation rate was normal. Sputum and agglutination studies were negative, when reported, although a light growth of pneumococci was obtained from the sputum of this patient. Intranuclear inclusion bodies were demonstrated in one patient[16] but a search in the sputum from our patient failed to reveal any inclusions.

Roentgenographic examination of the chest revealed the characteristic diffuse, nodular densities of varying size, with a tendency toward coalescence but without consolidation. The densities were usually greatest toward the hilum and gradually diminished toward the periphery. Clinical improvement in nonfatal cases occurred much more rapidly than the disappearance of the pneumonic infiltration, which can persist for weeks. There was nothing about the appearance of the chest x-ray that would enable one to prognosticate about the outcome.

A study of the reported cases of visceral varicella revealed that lesions were found in the skin, pharynx, trachea, bronchi, lungs, pleura, lymph nodes, myocardium, gastrointestinal tract, liver, spleen, kidneys, adrenals, and brain. Most commonly the lungs were involved, and the pathologic picture was similar to that described in this patient. The lungs were markedly increased in weight due to edema, and the pleural surfaces were studded with varicella lesions. Microscopically edema, congestion, and focal necrosis could be demonstrated; and the alveoli contained segmented neutrophils with an exudate of red blood cells, fibrin, and mononuclear phagocytic cells, along with desquamated alveolar septal cells. Intranuclear inclusion bodies could frequently be found in these alveolar septal cells as well as in focal areas of necrosis in other organs. In 1940, Johnson[17] made the first observation of intranuclear inclusions in varicella. These were not consistently present, and we were unable to demonstrate any in our sections. Pinkerton,[18] who reviewed our sections, believed that inclusion bodies were probably present at one time but then disappeared. He further stated that the necrotic lesions probably started in a single cell and adjacent cells were infected to form spherical foci. The lesions eventually burned out; but during the development of the lesions, inclusions were probably present. He compared this to the effect of neonatal herpes. Whether steroids in any way modified the picture is purely speculative.

Treatment

A variety of antimicrobial agents were used in this series of 22 patients. Sulfonamides, tetracycline, chlortetracycline, penicillin, streptomycin, oleandomycin, novobiocin, erythromycin, and chloramphenicol did little to alter the course. Even among patients who survived varicella pneumonia, little value was given to any antibiotic. In each instance they were employed with the hope of preventing secondary bacterial pneumonia, and for this purpose they may have been useful.

The role of steroid therapy in the treatment of disseminated varicella is uncertain. Patients with chickenpox pneumonia are described as becoming afebrile in 24 hours after receiving hydrocortisone or prednisolone.

Fitz and Meiklejohn[8] reported a case of a 25-year-old woman, three months pregnant, who was critically ill with chickenpox pneumonia. In addition to oxygen, tetracycline, and penicillin, she was given hydrocortisone intravenously; 24 hours later her temperature returned to normal, and she became less dyspneic. Except for the development of pleuritic chest pain seven days later, subsequent convalescence was uneventful until the sixth week, when a macerated fetus was aborted.

In November, 1958, Thompson and Cantrell[19] reported the case of a 31-year-old housewife with a severe cough, fever, and frankly bloody sputum associated with the vesiculopustular rash of chickenpox. She failed to respond to oxygen with nebulized Alevaire, sedation, and tetracycline. When she became more cyanotic and dyspneic and developed anterior chest pain with moist râles in both lung fields, prednisolone therapy, in a dosage of 40 mg. per day, was instituted. Within 24 hours her temperature had fallen from 103 F. (39 C.) to normal levels. The patient became less dyspneic and appeared greatly improved. Her sputum became rusty in color and rapidly decreased in amount. No new skin lesions appeared after prednisolone was initiated and those present rapidly regressed. Appetite and mental attitude improved, and at no time were there any adverse side-effects. A chest roentgenogram three weeks later revealed almost complete resolution of the pneumonic process.

Baird[20], in November, 1959, reported the case of a 28-year-old white soldier with chickenpox pneumonia who was dyspneic, cyanotic, and disoriented. When he failed to respond to aspirin, oxygen, intravenous fluids, penicillin, and chloramphenicol, hydrocortisone was given intravenously in a dosage of 300 mg. in 24 hours. Eight hours after the hydrocortisone was started, the patient was remarkably improved. His temperature returned to normal and he was no longer dyspneic, cyanotic, or disoriented. In the next four days he received prednisone orally, and his convalescence was uneventful.

Prompt clinical improvement following the use of steroids in these patients suggests that these agents may well be beneficial. However, even in seriously ill patients with chickenpox pneumonia, the clinical course may end abruptly without the benefit of steroids. In Case 20 (Table 1) cortisone was administered to a 23-year-old pregnant woman with disseminated varicella; and during the first 48 hours in the hospital her pulmonary condition improved slightly. She also received humidified intermittent positive-pressure oxygen and intravenous fluids with tetracycline. When the patient developed oliguria, melena, hematemesis, and increasing dyspnea, cortisone therapy was discontinued. Despite an extra-corporeal hemodyalysis, the patient died 17 days after the onset of the varicella eruption. The value of steroids in this patient is difficult to assess, since therapy was not continued. However, the patient described in this report was treated with substantial doses of hydrocortisone, intravenously and intramuscularly, within a few hours after the diagnosis of chickenpox pneumonia was established; and it was continued to his death less than 48 hours later. It did not appear in any way to modify the clinical course. Also, steroids were of no benefit to the patient in Case 12 (Table 1).

It has been reported that in some individuals undergoing cortisone therapy, chickenpox may be a severe and fatal disease.[21,22] Two of the patients in this series, shown in Table 1, had underlying lymphomas (Cases 11 and 21) and one had Boeck's sarcoid (Case 5). Five of the patients in this group were pregnant (Cases 6, 17, 18, 19, 20). The question arises as to whether there might be some alteration in the antibody response in these individuals that would render the disease varicella more virulent. That the antibody response in individuals with lymphomas and sarcoidosis is impaired has been emphasized repeatedly. The apparent severity of varicella in pregnant females may be related to their corticosteroid levels and may be likened to the severity of varicella in patients receiving steroids for other purposes. Viral diseases, such as poliomyelitis, are frequently more severe in pregnant women. Furthermore, the limitations that the tumor of pregnancy places on pulmonary function may contribute to the hazard of the pneumonia. Since 8 of the 22 reported deaths from varicella were in patients who were either pregnant or had lymphatic diseases, it seems likely that these factors may have predisposed them to the severe form of varicella. Three additional patients were non-Caucasians, but it is purely speculative whether racial factors contributed to the severity of varicella.

Summary

A fatal case of disseminated varicella in a 32-year-old Indian man has been reported. Clinical features included a diffuse vesiculopustular eruption, fever, pleuritic pain, severe cough, hemoptysis, dyspnea, and cyanosis. Treatment with salicylates, chloramphenicol, positive-pressure oxygen, and parenteral steroids failed to alter the clinical course.

Autopsy findings showed varicella lesions in the liver, spleen, stomach, skin, and extensive involvement of both lungs. No inclusion bodies were demonstrated.

This case brings the total number of reported varicella deaths in adults to 22. Of this number, 5 patients were pregnant females, and 3 additional patients had associated diffuse lymphatic disease. The significance of these factors in the severity of varicella has been discussed.

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ISCHEMIA OF THE COLON AS A COMPLICATION IN SURGERY OF THE ABDOMINAL AORTA

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Abstract from *Journal of the Michigan State Medical Society* 59:1711–1712 (Nov.) 1960.

In surgical procedures on the abdominal aorta, the surgeon often faces the problem of the simultaneous obliteration of the inferior mesenteric artery, and both internal iliac arteries as a necessary technical step in the operations for aneurysm or occlusive disease. In the latter condition, there is small cause for concern since the insidious obliterative process of atherosclerosis provides time for the development of an ample collateral circulation, and a correction of the main occlusive lesion almost invariably assures adequate blood supply to the colon. However, with regard to aneurysms of the distal abdominal aorta, the occasion frequently arises when sacrifice of patent internal iliac arteries, together with the ligation of the inferior mesenteric artery (which is always necessary) may lead to grave consequences. In the past, insufficient emphasis has been placed on the importance of this surgical hazard, partly because it occurs infrequently, and also because, in extensive aneurysmal disease, salvage of the internal iliac artery often seems impossible. Owing to lack of alertness about this problem and because of some unavoidable thrombotic mishaps and unforseen anatomic variations, in the course of the resection of 150 abdominal aortic aneurysms, we observed ischemic complications of this type ranging in severity from transient mucosal ulceration to massive gangrene on the left colon in thirteen instances.

In this essay, we review briefly these cases, and discuss the pertinent anatomic relationships as well as the methods of prevention and management of the ischemic complications.

Mushroom Poisoning: Report of Three Cases with One Death

By DUANE L. FLOGSTAD, M.D.

Shell Lake, Wisconsin

ABOUT 50 deaths occur per year in the United States and several hundred in the world from mushroom poisoning (mycetismus).[1] The Amanita genus is responsible for nearly all cases, and the delicious but deadly phalloides species causes over 90% of the fatalities. Occasionally Amanita muscaria may cause death. These two species are common in North America. Amanita verna, Amanita virosa, Amanita tenuifolia, Lepiota morgani and most recently a species from the genus Galerina[2] have been described as the cause of acute poisoning. Botanical means are the only way of identifying the type of fungus and this remains in the realm of the expert. Certainly pickers of only layman's training are embarking on a hazardous activity as was indicated in the following case histories.

Case Reports

Case 1—A 64-year-old, previously well, tavern keeper consumed a generous portion of freshly picked mushrooms along with his evening meal. He had picked mushrooms seasonally all his adult life for home consumption. At midnight, six hours later, he became acutely ill with nausea, vomiting, stomach cramps, and severe leg and foot cramps. Liquid stools began shortly thereafter. He was given 100 mg. of meperidine hydrochloride at home which relieved him only temporarily. He was admitted to the hospital the following morning with cyanosis, blood-tinged stools, and pinpoint pupils. Immediate treatment was begun with intravenous fluids, calcium gluconate, ACTH, oxygen, penicillin, streptomycin, and atropine. After 24 hours atropine was no longer necessary due to the remission of the muscarine-type symptoms. A microscopic hematuria was noted on the fourth hospital day; the icterus index climbed to 44.9 on the sixth hospital day. The hemoglobin level maintained itself at 16 gm. per 100 ml. throughout the period of illness. The white blood cell count rose to 27,700 on the second hospital day and dropped to 8,000 by the sixth hospital day. He was discharged on the seventh hospital day and subsequently has recovered completely.

Case 2—The 45-year-old wife of Case 1, previously well, consumed a large amount of freshly picked mushrooms with her evening meal. Before going to bed she ate a snack of mushrooms on bread. Violent stomach cramps began about midnight along with nausea and vomiting. Meperidine hydrochloride, 100 mg., relieved the symptoms only temporarily and she was admitted to the hospital the next morning in severe pain with diffuse muscular aches and abdominal cramps. Continuous intravenous fluids were begun along with the atropine. Atropine was no longer necessary after 24 hours. ACTH was begun the following day. On the fourth hospital day bloody stools began and jaundice was noted along with gross hematuria. She went into shock that day and was maintained for 24 hours with therapy including mephentermine sulfate, dextrans, whole blood, levarterenol bitartrate, vitamin K-1, soluble hydrocortisone and rapid digitalization. An icterus index of 59.9 was noted. The hemoglobin level remained at 17 gm. per 100 ml. throughout her illness. The white blood cell count dropped from 8,300 to 2,800. She died on the fifth hospital day.

Case 3—A 47-year-old female houseguest of Case 1 and Case 2 consumed approximately one teaspoonful of mushrooms with her evening meal. She became slightly ill during the night with gastrointestinal symptoms consisting of mild stomach cramps and nausea. After hearing of the illness of her friends, she came to the hospital for evaluation and was given a prescription for an antispasmodic. Stomach cramps continued to plague her and she was also admitted to the hospital later the same day. Her hospital course ran a benign path with treatment consisting of intravenous fluids, atropine, and soluble hydrocortisone. The icterus index remained normal throughout hospitalization, no hematuria was noted and the hemoglobin level remained at 14 gm. per 100 ml. An initial leukocytosis of 15,100 relented and she subsequently recovered completely. She was discharged on the seventh hospital day.

An 8-year-old daughter of Case 1 and Case 2 consumed the identical meal as her parents except for mushrooms. She did not become ill.

The mushrooms were identified as Amanita phalloides and Amanita muscaria.[3]

Discussion

The rapid type of poisoning (mycetismus nervosa) is caused by Amanita muscaria which contains the alkaloid muscarine. Symptoms are almost immediate and are

similar to pilocarpine poisoning. Lacrimation, salivation, perspiration, miosis, dyspnea, slow pulse, severe abdominal pain, watery and painful bowel movements, confusion, cardiovascular collapse, coma and occasionally convulsions are prominent features. Atropine provides a specific antidote. Prognosis is good in severe cases if this form of intoxication is recognized and atropine administered.

The delayed form (mycetismus choleriformis) is usually due to Amanita phalloides. Symptoms occur in 6 to 15 hours with sudden onset of severe abdominal pains. The gastrointestinal symptoms do not occur after experimental parenteral administration of mushroom extracts in animals. The gastrointestinal symptoms may dominate the clinical picture and result in rapid death with cholera-like manifestations. If this phase is overcome with appropriate therapy (fluids and electrolytes), a remission may take place followed gradually by more pronounced signs of parenchymatous injury of several organs, chiefly the liver. The terminal phase is initiated by general collapse, and finally coma. Anomalies of the blood glucose levels are observed with early rise, then greatly lowered levels. Capillary injury with retinal and conjunctival and cutaneous bleeding often is present. A hypoplastic anemia has also been noted. Postmortem findings show fatty degeneration of the heart, liver, kidneys (especially the tubules), and skeletal muscles. Extravasates at the serous and mucous membranes are noted and frequently swelling of the lymphatic tissue of the intestine. Often the adrenals show fatty degeneration and the central nervous system shows cellular damage. Inflammatory processes of the gastrointestinal tract are present. Prognosis has been grave with mortality rates at least 50% and sometimes approaching 100%. Death occurs in from five to eight days after ingestion of the mushrooms.

Five toxins of Amanita phalloides have been described along with experimental work in animals.[4] The toxins are phalloidin, alpha-amanitin, beta amanitin, gamma amanitin, and phalloin. The first two, phalloidin and alpha amanitin, are better understood because of experimental work; and it is alpha amanitin which is largely responsible for the toxic manifestations. The toxin phalloidin was the first to be crystallized. It primarily attacks the blood capillaries. Its action appears to be through a deactivation of enzymes with breakdown of the entire metabolism of the cells. The apparent hyperinsulinism activity present is probably due to inhibition of insulinase activity of the liver. Alpha amanitin is 20 times more toxic but it takes 20 times longer for death to occur. It also causes hypoglycema, but there is no modification of the lethal effect with concomitant intravenous glucose. Stimulation of adenosinetriphosphate and adenosinediphosphate appears to be the primary action of amanitin. There is complete inhibition of the conversion of glucose into glycogen which explains the failure of glucose therapy.

Both in phalloidin and in amanitin poisoning hepatic glycogen mobilization associated with blood glucose elevation must be considered the first demonstrable change. There is inhibition of important enzymes of carbohydrate, fat, and protein metabolism at an early stage. Synthesis of protein is interfered with, chiefly the albumen fraction. The fatty degeneration of organs is apparently a secondary nonspecific process. The liver hemorrhages indicate an attack on the structures of the hepatic capillaries and cell interfaces in general. Lethal activity is in those areas of the cell where biological function depends on integrity of microstructures, i.e., in the largely unexplored field of living membranes. Possibly these ring-shaped molecules possess particular affinity to certain structural cell elements and at these sites induce disturbances of vital processes.

Summary

Three patients were treated for acute mushroom poisoning caused by ingestion of Amanita phalloides and Amanita muscaria. This situation was highly unusual in that two varieties of poisonous mushrooms were consumed. The clinical picture was predominantly that of phalloides intoxication. Two patients survived. In the past, 50 to 100% mortality has been experienced from phalloides poisoning. The five toxins isolated from Amanita phalloides appear to work through a deactivation of enzymes with breakdown of the entire metabolism of the cells. The damage appears to be at the level of the microstructure of cells in the largely unexplored field of living membranes.

Symptomatic treatment was instituted. Steroid therapy was used and may have

played some role in the recovery of two patients. It is apparent that dosage of toxin has much to do with the outcome.

Atropine is the accepted cornerstone of therapy for mycetismus nervosa due to Amanita muscaria intoxication. Judicious fluid and corticosteroid therapy would seem a rational basis for therapy for the highly lethal mycetismus choleriformis (usually due to Amanita phalloides ingestion).

Shell Lake Clinic.

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COMMENTS ON TREATMENT

Some Random Questions and Answers

By HARRY BECKMAN, M.D.
Milwaukee, Wisconsin

IN *barbiturate intoxication* what is of prime importance?

Treatment is directed toward overcoming coma, combatting the depressed respiration and cardiovascular collapse; but the thing of paramount importance is maintenance of adequate oxygenation.

In what situation particularly may *mercurial diuretics* still be best?

In acutely ill patients, in whom immediate response is imperative or oral administration impossible, mercurial diuretics are still the drugs of choice.

In what diabetics may *combined oral and insulin therapy* be expected to have merit?

In patients in whom insulin alone does not permit satisfactory control; i.e., in those with brittle diabetes or insulin resistance.

What may be a nonandrogenic side-effect of *norethandrolone (Nilevar)*?

There are indications in recently published studies that norethandrolone may under some circumstances produce hepatic dysfunction.

What is the chief difficulty in employing *griseofulvin (Grifulvin)*?

The drug is fungistatic rather than fungicidal; therefore, long-term therapy is required to insure removal of all infected structures.

What may be an organic side-effect in prolonged *isoniazid-PAS therapy*?

Prolonged administration of these drugs may depress thyroxin production with no overt signs of goiter or hypothryroidism. Therefore all patients with tuberculosis on prolonged treatment with isoniazid-PAS should be frequently observed for possible subclinical hypothyroidism.

What is the chief advantage of the *thiazide derivatives*?

The action of the thiazide derivatives, whatever its intimate mechanism may prove to be ultimately, is in effect no more than a depleting measure, such as can be achieved with other diuretic drugs. A rigid low-salt diet will accomplish the same thing. The only advantage—but a great one—that the thiazide derivatives have is the ability to deplete the patient with a milder assault on his sense of well-being.

DURING 1960, almost one out of every five contacts between U. S. patients and physicians in private practice did *not* involve actual sickness or injury. Figures released by the National Disease and Therapeutic Index (N.D.T.I.), a continuing statistical survey of private medical practice, attributed 18% of all patient visits to special conditions without sickness. Prominent among these special conditions were prenatal care, inoculations and various examinations. In total they accounted for more trips to the doctor than either of the two leading disease categories, respiratory and circulatory disorders. N.D.T.I. results point up a major role of the American physician in maintaining the good health of "well" patients. N.D.T.I. collected data from approximately 2700 doctors during 1960. The study estimated a grand total of 972 million individual diagnoses were made by physicians for private patients in the U. S. last year.

Making Swimming Pools Safe

CEASER A. STRAVINSKI

Madison, Wisconsin

THE AMERICAN people are noted for living at an accelerated pace and for their preoccupation in obtaining social and economic recognition. Members of the medical profession have indicated that such preoccupation brings about tensions and resulting ulcers and heart attacks.

To offset this we throw ourselves whole heartedly into many forms of recreation—bowling, golfing, hunting, fishing and swimming. In the past, most of our swimming was done in the lakes and rivers that are plentiful in our state. However, since we have become fastidious about the water we swim in and are conscious of the many diseases that can be contracted from swimming in polluted water—amoebic dysentery, typhoid fever, paratyphoid fever, leptospirosis, respiratory infections, to name a few—more communities and individuals are constructing pools to provide a safe swimming environment. In addition, many motels are installing pools in an effort to ensure full occupancy.

Numerous factors must be taken into consideration to secure a safe swimming environment, so the State Board of Health has recognized the public health problems that could arise from pools that do not provide adequate facilities. The Board requires that plans and specifications for public pools be submitted to the Section on Sanitary Engineering for review and approval. This requirement applies only to pools serving the public, and excludes pools constructed at individual homes or apartment buildings containing less than ten living units. Plans for private pools should be reviewed by local public health departments.

The four most important factors that are considered essential to provide a safe swimming environment are: bacteriologically safe water, water clarity, safety precautions, and adequate supervision. The first two are accomplished by providing adequate filtration, recirculation, and disinfection equipment. The pool water must be continually returned to the filters to effect removal of bacteria and foreign material and to increase the effectiveness of the disinfectant. Facilities for continual skimming of the surface must be installed to remove floating material and body oils. It is not economical or practical to waste the water because of the increased cost of operation and the decrease in the temperature of the pool water resulting from the addition of make-up water. A surge tank normally is provided to receive the overflow, and the water is then returned to the filters. A disinfectant must be proportioned to the flow from the filters to kill bacteria that are carried into the pool by the bathers.

There can be other hazards to the people using the pool. For example, there must be an adequate depth of water below the diving boards and sufficient head room above. The diving hopper must be of sufficient length and of such profile as to prevent possible impact of the diver with the floor. Projections into the pool proper, except for a safety ledge or ladders, are considered unnecessary. The depth of the water at the shallow end of pools should be dictated by the proposed use. The floor should slope uniformly to the diving hopper.

Even if the pool has been properly constructed and contains all the essential equipment to provide a satisfactory water for swimming, it must have proper supervision. Lifeguards must be impressed with the fact that the safety and lives of the swimmers will depend on how well they perform their duties. Horseplay and a disregard for others have no place in a pool. In order to assure a safe swimming environment, frequent checks must be made of the chemical and bacteriological quality of the water. Inattention to the proper operation of the equipment, carelessness in cleaning, and disregard of regulations will result in a pool that will be no better than a pond.

As indicated previously, the Board has not, up to the present, decided to regulate private pools. Each community can adopt an ordinance regulating the construction of such

Mr. Stravinski is Director, Division of Public Water Supplies, Wisconsin State Board of Health.

one of a series

Medical Stamps

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BRANCO
(1825–1890)

A Portuguese who studied medicine and later began writing novels. He became one of Portugal's greatest novelists and dramatic writer. In 1885 he was created Viscount of Correio–Botelno. In 1925 Portugal honored him on several stamps in a series valued 15c, 25c, 40c, 1.60e, 4.50e. #353, 356, 359, 364, 369, 374. Here is shown #359.

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Donders was a young army surgeon of the Netherlands who became Professor of Physiology at Utrecht. Later he specialized in ophthalmology and wrote his famous book "Anomalies of Refraction and Accommodation" which was published in England in 1864. In 1935 his country issued a "cultural relief" issue and Donders is shown on the six-cent stamp. #B79.

* * *

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pools which will afford some protection to the health of its citizenry. As a minimum, each pool should (1) be surrounded by substantial fencing, (2) be provided with filtration and recirculation equipment, (3) have facilities for disinfecting the water and have test equipment available to substantiate the effectiveness of the facilities, (4) contain no direct piping connection with either the drinking water supply or sewer system, and (5) be properly supervised while in use. Individuals contemplating the construction of a pool at their private residences should carefully consider the advantages and disadvantages that will result from such action. In order to provide many hours of pleasant recreation, time will have to be allotted to the proper care and maintenance of the pool.

All concerned with the installation of pools should do their utmost to make sure that the pools are properly constructed, operated, and supervised so that they will be a means of providing pleasant relaxation from the many cares and trials of our everyday lives.

EVALUATION OF BILLROTH I OPERATION WITH VAGOTOMY FOR TREATMENT OF DUODENAL ULCER

ROBERT REYNOLDS, M.D., and ROLAND P. REYNOLDS, M.D., Detroit. Abstract from *Journal of the Michigan State Medical Society* 59:1563 (Oct.) 1960.

Beause of the recent diversification in the surgical management of duodenal ulcer, it is possible to select the operation best suited for each patient.

If feasible, vagotomy is done in all our ulcer operations, and this may be accompanied by a fifty per cent resection or gastrojejunostomy. From 1952 through 1957, 237 operations were done for duodenal ulcer. Sixty-two of these operations were Billroth I, 50 per cent were vagotomies. The technique is discussed in detail. The ulcer is not necessarily removed and a gastroduodenostomy is done only if a safe anastomosis can be made. The results of this procedure have been very good, with only four per cent of patients reporting dissatisfaction. The combination of doing a more limited resection and vagotomy provides a more normal physiological approach to the ulcer problem. The immediate postoperative complications, such as nutritional deficiencies, dumping, and marginal ulcer, appear to be definitely decreased.

We recommend the Billroth I, 50 per cent resection and vagotomy as the operation of choice in those patients in whom it can be performed safely.

Sponsored by Section on Pathology
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CLINICOPATHOLOGIC CONFERENCE

Guest Editor: J. N. BOGER, M.D.
Marshfield, Wisconsin

CASE PRESENTATION*

This nine-day-old white male infant was admitted to the hospital because of diarrhea which began the day before. He had been fussy for the two previous days. He passed small amounts of watery, yellow stool about every two hours. There was no blood in the stools and there was no vomiting. He cried as though he were having abdominal pain. He also became anorectic, since he had taken only 5 ounces of formula in the preceding 24 hours instead of his usual 18 to 20 ounces. His formula was 18 ounces of water with 13 ounces of evaporated milk. He was the first child. The prenatal period and delivery were uncomplicated, and he had done well until the present illness. His birth weight was 3.7 kg. (8 pounds 1 ounce).

This was a well developed, lethargic, dehydrated baby with ashen color, weighing 3.3 kg. (7 pounds 4 ounces). His temperature was 99.4 F. and pulse rate 120 per minute. The skin turgor was poor. There was injection of the pharynx with no exudate. The ears and eyes were normal. The anterior fontanelle was depressed. The neck was supple. There was no lymphadenopathy. The lungs were clear and the heart had a regular rhythm and no murmurs. The abdomen was soft and without masses or enlarged liver or spleen. The testes were descended. The penis was somewhat large and the scrotum slightly pigmented. A Moro reflex, a concussion reaction, could be elicited. There was a small amount of yellow, soft, formed stool in the diaper.

The hemoglobin level was over 20 gm. per 100 ml., hematocrit reading 71%, white blood cell count 32,700 with a differential of 66% neutrophils, 6% band forms, 3% eosinophils, 24% lymphocytes and 1% monocytes. The urine was acid and had a trace of glucose, 75 mg.% albumin, no acetone, 1 to 2 white blood cells per high-power field, 5 to 10 red blood cells per high-power field, 1 to 4 casts per high-power field, and amorphous urates. The quantity was insufficient for specific gravity. The throat culture grew 50% coli aerogenes and 50% beta hemolytic Streptococcus. The stool culture grew coli aerogenes. No enteric pathogens were present. The blood culture grew Staphylococcus aureus, coagulase positive.

Therapy initially consisted of intravenous fluids, 125 ml. of a solution of 5% dextrose in Polysal and 125 ml. of a solution of 5% dextrose in water. His oral intake was 90 ml. of glucose water. Several hours after admission the infant appeared worse and had a weak cry. A lumbar puncture yielded crystal clear fluid with one lymphocyte and normal protein and glucose content. There was no growth on aerobic and anaerobic culture. The infant was placed in an incubator with oxygen. Aqueous penicillin 300,000 units and streptomycin 100 mg. were given at this time and continued every six hours at 200,000 units and 50 mg. dosages respectively. Intravenous fluids, 250 ml. of a solution of 5% dextrose in Polysal, were continued by a cutdown. During the night there were twitching movements of the face and extremities for which 30 mg. of phenobarbital was given.

In the morning the infant was gray and had occasional twitching movements. The skin turgor was still poor. Five ml. of a solution of 10% calcium gluconate in water was given intravenously.

The serum sodium was 117 mEq./l., chloride 78 mEq./l., potassium (hemolysis), carbon dioxide 21 mEq./l., and calcium 8.6 mg. per 100 ml. blood. An eosinophil count was 2,000 per cubic mm. He was given intravenously 25 mg. of hydrocortisone immediately and 75 mg. in 250 ml. of 5% dextrose in normal saline. The infant failed to improve and died three hours later, about 26 hours after admission.

Comment

Dr. J. R. Heersma: This is a nine-day-old male infant who had been irritable for just two days prior to admission and was said to have diarrhea for only one day. He was the first child in this family. He had poor turgor, a depressed anterior fontanelle, and appeared to be in shock. Other significant findings were the somewhat enlarged penis and pigmentation of the scrotum. There was no comment on his areolae. His white blood cell count was elevated and the differential was somewhat unusual for this age with a large percentage of neutrophils. The urine contained red blood cells and albumin. A beta hemolytic Streptococcus was cultured from his throat and a Staphylococcus aureus from the blood.

* From St. Joseph's Hospital.

In essence then, this is a child who presented in early life marked dehydration out of proportion to the one-day history of diarrhea with a soft, formed stool in the diaper at the time of admission. Thus, the diarrhea may not have been the sole cause of his in extremis condition. The initial laboratory work, including the white blood cell count, would suggest the child had either an infectious problem or was in extremis with a nonspecific white blood cell response. He was treated in a conventional manner with appropriate dosage of intravenous fluids. He had clear spinal fluid, and I assume that the tap was performed in spite of the depressed fontanelle because of the possibility of central nervous system infection. He had received relatively high doses of penicillin and streptomycin because of the possibility of an infectious process.

The course was one of continued deterioration and the following morning his serum sodium and chloride levels were extremely low. His eosinophil count was quite high. There was moderate reduction of his serum carbon dioxide content.

The patient presented a rather unusual picture of an extremely ill child that appears to be out of the realm of simple diarrhea and would most likely fit the possibility of a congenital adrenal hyperplasia with salt-losing syndrome. This is difficult to prove in a child in extremis such as this one. It is one of the causes of sudden death in children in this age group.

Most of the cases of congenital adrenal hyperplasia with salt-losing syndrome occur in the first two weeks of life with most of them in the first week. Diarrhea, which was the first complaint in our patient, is not a common one. It occurred in only 33 to 40% of a series of cases reported in 1955.[1] There were only 2 of 135 that had diarrhea without vomiting. Most of the patients were dehydrated and lost weight as did our child. Crises, as observed in our patient, occurred in 85 of the 135. The pigmentation is not seen commonly because it does not have time to develop. If an electrocardiogram had been made, we would have expected to see tall peaked T waves.

There are a few unusual conditions from which this disease must be differentiated. Adrenal tumor can usually be differentiated, if the patient lives long enough, by the response to therapy with cortisone. Adrenal insufficiency can also be caused by either hypoplasia of the adrenal or adrenal cysts. Relative adrenal insufficiency in the first few months of life has been described. Children with this condition ordinarily do well as they grow older.

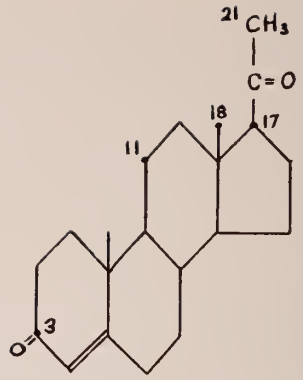

Fig. 1—Structural formula of progesterone with important positions numbered.

Because of the genital changes in our patient, I would assume this child had congenital adrenal cortical hyperplasia. This disease is transmitted by a recessive gene or genes which control two specific enzyme systems in the adrenal cortex. There are several types. The three most important are the simple uncomplicated adrenogenital syndrome, the type which has hypertension and the type which we have here, namely the salt-losing syndrome. If there is a family with one type, all the children involved in that family will have the same type. We do not see the salt-losing type and the hypertensive type in different members of the same family. These are said to involve about 25% of the siblings. There is a 25% chance of another affected child in the family of our patient. We know that parents of children with cystic fibrosis may have elevated sodium and chloride levels in their sweat as a manifestation of their heterozygotic state. If parents of patients with adrenal hyperplasia are given ACTH, they will have a slightly increased excretion of pregnenetriol as compared with the controls. This is evidence of a minimal enzymatic defect. If hormone studies are done on these children, they are usually found to have an increase in their ACTH. ACTH is measurable in this group, whereas in the normal infant of this age ACTH is not measurable. As far as sex distribution is concerned, the salt-losers are more common among males and the uncomplicated

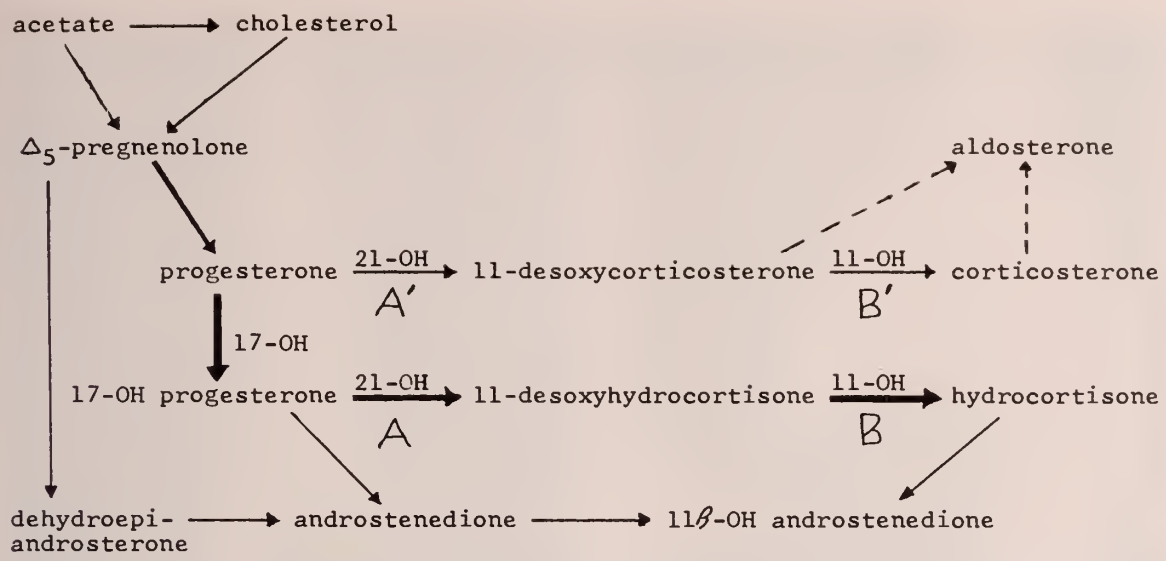

Fig. 2—Schematic representation of steroid synthesis in the adrenal cortex. A and A′ indicate enzyme deficiency in compensated and salt-losing variants of congenital adrenal hyperplasia. B and B′ indicate the deficiency in hypertensive variant.

congenital adrenal hyperplasia conditions are more common among females. This has been subject to some discussion as there is a strong possibility that the female preponderance in the uncomplicated cases is because the more obvious genital disturbance brings more females to medical attention.

The disorder in the adrenal metabolism in these patients consists of a block at A–A′ (Fig. 2). There is inadequate production of hydrocortisone and aldosterone which causes salt loss. The pituitary does not have the inhibitory effect of these substances, so it produces more ACTH in an effort to correct the deficiency. This causes more adrenal cortical activity with an increased production of androgenic substances that produce the masculinizing effects. Virilization in males is not common in the salt-losers because the children usually do not live long enough to have the obvious changes take place.

Therapeutically the situation is one of dire emergency. These children need sodium and chloride and this is given in relatively large amounts intravenously. Occasionally they need *l*-norepinephrine (Levophed) to maintain their circulation. Hydrocortisone and desoxycorticosterone acetate (Doca) are also given. If they survive the period of crisis, they are maintained on hydrocortisone, desoxycorticosterone acetate and sodium chloride. After one to two years, desoxycorticosterone acetate may be discontinued and extra salt is required only occasionally. They can usually be maintained in nonstress situations on hydrocortisone alone. Thus, there is an improvement in the electrolyte regulating function with age.

Discussion

Dr. J. N. Boger: There was slight enlargement of the penis, pigmentation of the scrotum, and dehydration of the skin. The adrenals were hyperplastic (Fig. 3). Their combined weight was 20 gm., over twice the normal weight for this age. On the left, in figure 3, is a cross section of the adrenal of this patient. The cortex was thickened and the convolutions were prominent due to infolding of the hyperplastic cortex. In the center, in figure 3, is the adrenal of a normal infant and on the right, that of a young adult. Histologically, there was a narrow, indistinct zona glomerulosa. The great majority of the cortical tissue was made up of closely packed cells of fairly uniform size which tended to have the columnar arrangement of the zona fasciculata. The reticularis was not well defined. The degenerating fetal cortex was noted in the central portion of the cortex.

In both lungs extensive focal hemorrhage was seen, probably related to the vascular collapse associated with the adrenal insufficiency. The kidneys were small, being two-thirds normal size for this age. Small kidneys have been frequently described in this disorder. In addition there was bilateral hydronephrosis and hydroureter due to the presence of ureterovesical valves. The hydro-

Fig. 3—Cross section of hyperplastic adrenal, left; normal infant adrenal, center; and normal young adult, right.

nephrosis was mild. The main histologic alteration in the kidneys was dilatation of the collecting tubules. The pituitary is of interest because there is an increased secretion of ACTH in congenital adrenal hyperplasia. A periodic acid-Schiff stain demonstrated no remarkable increase in basophils which are thought to secrete ACTH in addition to gonadotropins and thyrotropin. However, one should consider this with some reservation because to get an accurate quantitation of cell types in the pituitary, counts on multiple levels through the whole gland are necessary. A probable or moderate increase in basophils has been reported in 9 of 12 cases, but the accuracy of some of these evaluations is questionable.

The pathophysiology consists of a defect in one of the essential hydroxylation steps involved in the synthesis of hydrocortisone and aldosterone. Both in the normal adrenal cortex and in congenital adrenal hyperplasia the rate of synthesis is greater in the direction of hydrocortisone with a ratio of about 13:1. This is indicated by the heavier arrows in figure 2. In the uncomplicated or compensated cases of congenital adrenal hyperplasia and in those with the salt-losing syndrome, who constitute about one-third of the total number of cases, there is a deficiency of 21-hydroxylase (A–A′). As a result of the block and the increased cortical activity ensuing because of greater ACTH stimulation, 17-hydroxyprogesterone and progesterone accumulate in the gland and are released into the blood. They are metabolized by the liver. Their metabolites, chiefly pregnenetriol and pregnanediol, are found in large amounts in the urine.

In the rare cases of the hypertensive variant there is a deficiency of 11-beta-hydroxylase (B–B′). Consequently, there is an increase in circulating 11-desoxyhydrocortisone and desoxycorticosterone and an increase in the urine of their metabolites. The hypertension is thought to be due to the high level of desoxycorticosterone. However, all patients with 11-beta-hydroxylase deficiency do not have hypertension.

In all variants of the disease there is progressive virilization with pseudohermaphroditism in the female and macrogenito-

somia praecox in the male. A greatly increased excretion of 17-ketosteroids is present. Androsterone is the major 17-ketosteroid found in the urine, although several others, including 11-oxygenated steroids, are present in quantity. It is not known exactly what the actual androgen is that is secreted by the adrenal in congenital hyperplasia to yield these excretory products.

Since the salt loss and the consequent dehydration, shock, and state of adrenal crisis are the striking features of this patient, I would like to mention some of the current ideas regarding the mechanism of the salt loss. It is attributed to the severe lack of hydrocortisone, to aldosterone deficiency, or to the production of a salt-losing hormone by the disordered adrenal metabolism. Each of these theories explains some of the facts available, but none of them satisfactorily accounts for all of the data.

Theoretically, aldosterone production as well as hydrocortisone would be reduced by a deficiency of 21-hydroxylase. However, there has been considerable variation in the aldosterone levels reported in salt-losing patients. Earlier studies showed normal or increased levels. Recent studies by Blizzard et al.[2] and Lieberman and Luetscher[3] show low normal to greatly reduced levels. The former investigators also have shown that the aldosterone-producing capacity of the normal infant deprived of salt is limited as compared to the normal adult. The infant with the salt-losing syndrome has no ability to increase his aldosterone production while the infant with compensated adrenal hyperplasia has a greater-than-normal aldosterone production in response to salt deprivation. As determined by measuring urine excretion products, there is a marked reduction in hydrocortisone production in the salt-losing infant. This lack of hydrocortisone may be critical. A small amount of hydrocortisone, insufficient to suppress steroid production, was found necessary to control salt loss, even though the infant was given aldosterone.[4]

All infants, both normal and those with compensated and salt-losing adrenal hyperplasia, will lose salt if given ACTH. This, among other considerations, has spurred search for a salt-losing hormone. Several investigators have extracted an unidentified factor producing salt loss in rats from the urine of patients with congenital adrenal hyperplasia, normal infants given ACTH and patients with periodic familial paralysis.[5] Assessment of the significance of these factors in human electrolyte metabolism awaits purification, identification, quantitation and testing in humans.

Reverting to less speculative material, Doctor Heersma has indicated that most of these infants with the salt-losing syndrome develop a crisis picture in the first or second week of life. The error in the adrenal metabolism is present in utero, of course, and the virilizing effects can be noted in the female between the third and fifth month of gestation. However, because the placenta controls fetal electrolyte balance, the infant is born with a normal electrolyte status and consequently does not develop clinical signs for several days.

In summary, our final diagnoses in this patient are congenital adrenal hyperplasia with the salt-losing syndrome, mild bilateral hydronephrosis and hydroureter due to ureterovesical valves and extensive focal pulmonary hemorrhage. Post mortem culture of heart blood was sterile. There was 41 mg. urea nitrogen per 100 ml. blood.

Doctor Griese, do you have any comments about prognosis in this disorder?

Dr. G. G. Griese: For the first 12 to 15 hours after the infant was admitted to the hospital, the presumptive diagnosis was septicemia. If we can accept the positive blood culture as being valid, this certainly added to the infant's rapid downhill course. Specific adrenal replacement therapy was begun the following morning, and acid-base studies were made which confirmed the clinical impression at that time. Obviously this replacement therapy was begun too late. Of interest in that regard, is a family I once followed. The first baby was admitted, treated for sepsis, and died. At autopsy adrenal hyperplasia was noted. We were prepared for the next two infants that were born to this family. Although they were treated early and vigorously with adrenal therapy, they both died.

There is debate on the mechanism of salt loss. Fairly normal aldosterone levels are found in salt-losers.[4] In the salt-losers there is none of the metabolite products of hydrocortisone in the urine; this would indicate deficient hydrocortisone production. In individuals who do not exhibit salt-losing characteristics, there are large amounts of

metabolites of hydrocortisone in the urine which could be interpreted as meaning overproduction and nonutilization of hydrocortisone. There is another group in which the metabolites of hydrocortisone are at an intermediate level between the above two groups, and these seem to be the individuals who will develop salt loss during stress situations.

Doctor Boger: One of the objections to attributing the salt loss entirely to a severe hydrocortisone deficiency is that it would be expected that such a deficiency would also affect carbohydrate metabolism, as in a patient with Addison's disease, and disturbance of carbohydrate metabolism is rare. Also, Migeon[6] has shown that there is wide error in evaluating infant hydrocortisone production by measurement of urinary excretion products, since both their pattern and rate of degradation and excretion differ from the adult.

Dr. F. N. Lohrenz: Will giving progesterone in the first trimester of pregnancy produce this syndrome?

Doctor Heersma: There are cases of pseudohermaphroditism caused this way, but it will not produce this syndrome with the enzymatic defect.

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EXPERIENCE WITH ILEO–RECTAL ANASTOMOSIS IN ULCERATIVE COLITIS

James Barron, M.D., Laurence S. Fallis, M.D., and Eduardo Camacho, M.D., Department of Surgery, Henry Ford Hospital, Detroit.

Abstract from *Journal of the Michigan State Medical Society* 59:1563 (Oct.) 1960.

The operation of total colectomy in the surgical treatment of ulcerative colitis has received general acceptance by surgeons but many patients are loathe to accept a procedure that involves the formation of a permanent artificial anus in spite of the newer ileostomy technics and the development of dependable appliances. The reluctance is too often shared by their medical advisers and in the case of children by parents and guardians. As a result of this attitude too many patients are submitted to operation only as a last resort.

The generally unsatisfactory result of segmental resection, analileostomy, et cetera, has delayed development of techniques to preserve the sphincteric apparatus until interest was again stimulated by Abel and Aylett in 1956. Their preliminary and subsequent reports indicate the apparently good results of ileo-rectal anastomosis in a relatively large series of patients. This encouraging report led us to explore the possibilities of this procedure beginning in 1957.

The results of our experience with ileo-rectostomy in twenty-five patients is presented. Selection of patients, emphasizing indications and contra-indications, is discussed. Special attention is directed to the type of anastomosis employed in these cases and reference is made to experimental studies in this field.

INCIDENCE AND DISTRIBUTION OF ADENOMATOUS POLYPS OF THE COLON AND RECTUM BASED ON 1,000 AUTOPSY EXAMINATIONS

T. C. Arminski, M.D., Detroit.

Abstract from *Journal of the Michigan State Medical Society.* 59:1563 (Oct.) 1960.

One thousand colons and 117 rectums undergoing autopsy were carefully examined for polyps. The location, size and gross characteristics of all polyps were tabulated, and microscopic sections were made of all grossly recognizable lesions.

Approximately 50 per cent of all specimens showed the presence of adenomatous polyps. The incidence after the seventh decade was three times as great as during the third and fourth decades. In the colon, approximately half of the polyps were on each side respectively. Including the rectum, approximately one-third of the polyps were in the rectum and one-third each on the right and left side of the colon. Based on the distribution found, about 40 per cent of the polyps would have been visible with a 25 cm. sigmoidoscope. Sixteen per cent of the colons had polyps over .5 cm. in diameter, and 7.1 per cent had polyps over 1 cm. in size. Both the total incidence of polyps and the size increased in the older age group. About half of the cases with polyps had single ones, and the other half multiple ones. The single polyps were equally distributed on each side of the colon. The multiple polyps were all situated on the right side in about 25 per cent of the colons; nineteen per cent on the left side and on both sides in 56.5 per cent.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Are We Men or Sheep?

PICKING ON the American Medical Association has become a popular indoor sport with that section of the American press that favors tax-supported medicine. As part of the effort to give color to the image of a service profession held in thrall by a "trust" or "union" controlled by ultra right-wing elements and semi-retired, wealthy, non-working "political" doctors, the impression is conveyed that the average doctor doesn't dare disagree publicly for fear of being put out of business by "Organized Medicine."

Unfortunately too many doctors are content to remain silent, thus lending credence to the impression that is created. Because these false ideas are left unchallenged, except in medical publications which are read only by doctors, the public begins to accept them as gospel.

Those of us who are members of the AMA, of the State Medical Society and of county societies know that our organizations are truly democratic—in structure as well as in function. Yet they suffer not only from the sniping of some of their members but from the erosion resulting from the silence of a great many doctors who are reticent about personal endorsements for reasons of modesty, expedience or just plain indifference.

Disagreement is natural, and a democratic prerogative. If a member disagrees with the policies of his organization, let him say so within the organization where his voice can help form policy. If his disagreement is so basic that there is no common ground, let him resign.

On the other hand, if he supports the policies of his organization, as do the majority of the members, let him make his position known publicly.

One way or another, doctors should stand up and be counted. Let us end the prevalent fallacy that the members of the medical profession are a bunch of sheep led by a few Judas goats.

Un-American Activities

THE CRACKPOT, the crank and the common, garden-variety screwball have always been characteristic of our democracy. Viewed as a fragment of the lunatic fringe,

the John Birch Society may seem more ridiculous than worthy of concern. But what this group and its wealthy leader and founder, Robert Welch, stand for will produce a sick sensation in the stomach of every patriotic American. The information that prominent medical men in several communities have associated themselves with the John Birch Society causes dismay and consternation among doctors of sense and perception.

The John Birch Society purports to fight Communism. To do this it organizes secret and semi-secret groups who look around their own communities for Communists to expose. The society's "Blue Book" urges "mean and dirty techniques," underground infiltration, front organizations, and, in fact, all the methods the Communists themselves use. Among the Americans whom Robert Welch, a retired candy manufacturer, thinks might be members of the Communist underground were President Eisenhower, Dr. Milton Eisenhower, the late Secretary of State John Foster Dulles and his brother, Allen Dulles, now head of the Central Intelligence Agency.

The John Birch Society is, in its structure, frankly authoritarian. It insists that there be no accounting of the funds contributed to it "for reasons you will understand." It regards democracy as a "weapon of demogoguery and a perennial fraud."

Naturally, this kind of a set-up has attracted such characters as J. B. Matthews, one-time super-sleuth for the late Senator Joseph B. McCarthy, who got fired from his job for picking on American clergymen as supporters of the Communist apparatus. It gathers the perennial paranoiac who sees a conspiracy against him in every healthy, happy development of our nation. It is ready-made for that slimy corruption of the body politic that would disgrace the underside of a rock. It is the apotheosis of the Silver Shirts, the American Vigilantes, the Crusaders for Economic Liberty and other demented hate groups of the 1930's and early 1940's, and it draws together the survivors of these unfortunate, but happily defunct organizations. Cloaked with a phony respectability and supported by big money, the organizers of the John Birch Society would make such fellow operators as Gerald L. K. Smith, William D. Pedley and Gerald Winrod turn green with envy. That a few medical men, who, of all people, should have a sense of balance and be perceptive to social disruption for ulterior motives, are members of the John Birch Society, or its affiliates, is a disgrace to the entire profession.

There is room in our democracy for difference of opinion, and, as a nation, we exercise our right to dissent almost to the point of license. But there is no room for the betrayal of our ideals, and the John Birch Society is an avowed opponent of the democratic ideal expressed in a republican form of government. It says it is anti-communist; it is really anti-democratic. Robert Welch and his minions call themselves ultra-conservative. They takes as their heroes the late Senator Robert Taft and General Douglas MacArthur. Senator Taft can't defend himself and General MacArthur has not yet commented. But there is no question, after what has happened in communities like Glenview, Illinois, and Santa Barbara, California: the John Birch Society is anti-democratic. Its theme is hate, its method disruption. Like the Nazi party in Germany, it uses anti-communism as a tool to establish a totalitarian America.

Hunting traitors, communist or any other kind, is the business of the Department of Justice and the Federal Bureau of Investigation. Over the years, these organizations have done their job well—far better than local loud-mouths who looked for communist propaganda in Girl Scout handbooks and found enemy agents where none existed. This country does not need private vigilante groups to protect our institutions. We don't need the John Birch Society and its conspiratorial methods. Our country is strong in its faith, firm in its ideals, and steadfast in its devotion to the principles which the John Birch Society abhors.

It is to be hoped that the doctors who have allowed their names to be used by the John Birch Society are innocent victims of misinformation. Let them serve as examples for the rest of us who love our country and cherish democracy. Let us beware of being deceived by high-sounding, super-patriotic organizations whose ultimate aim is the destruction of our nation. Let us use the same perception in the diagnosis of political evil that we would use in the diagnosis of physical maladies.

Let us shun the John Birch Society and its front organizations like the plague.

—D. N. G.

Minutes of Council Meeting

Madison, Wisconsin, February 25-26, 1961

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 2:15 p. m. on Saturday, February 25, at Society headquarters in Madison.

All voting members of the Council were present except Doctors Hill, Blanchard, Ekblad, and Van Hecke. Also present were President Sorenson; President-elect Lokvam; Treasurer Weston; Speaker Nordby; Doctors Simenstad, Bernhart, Galasinski (Saturday only), and Quisling, AMA delegates; and Doctor Stovall; Doctors Tormey and Gearhart, Saturday afternoon. Staff and consultants: Messrs. Crownhart, Thayer, Ragatz, Toser, Murphy, White; Mrs. Anderson; Misses Rendall and Pyre.

2. Approval of Minutes of November Meeting

Doctors Fons and Egan objected to that portion of the minutes reporting action on a statement and recommendations concerning Resolutions G–H and I presented with approval of the Executive Committees of the Commission on Medical Care Plans and of the Council.

Following discussion, Doctors Dessloch–Kief moved that the minutes be approved as circulated. Doctors Kilkenny–Fons proposed an amendment that the minutes be approved with deletion of that portion dealing with Resolutions G–H and I adopted by the House of Delegates, May 1960.

There was further discussion and requests that minutes of the two Executive Committees be read "for authority for the statements of Councilor Dessloch." The Secretary read the October 20 minutes of the Commission Executive Committee and the November 4 minutes of the Council Executive Committee when presentation of the statement to the Council on November 5 was approved.

When put to a vote, the amendment was lost and the original motion carried. Doctor Fons asked to be recorded as voting "no."

3. Rules of Order

On motion of Doctors James–Houghton, carried, the Council adopted material prepared by the Executive Committee including sections of Robert's Rules of Order and past actions and traditions of the Council which constitute Rules of Order of the Council for the conduct of its meetings.

4. Report of Committee on Public Policy

Doctor Quisling presented current information on legislation of interest to medicine, already introduced or under consideration by the committee or other groups:

(a) Bills 2, S. and 3, S. relating to the improvement of local public health organization in Wisconsin. The Council has had prior information on these bills and the Society has supported such measures since 1946. Supporting statements will be filed with regard to each.

(b) He summarized legislation proposed by optometric and chiropractic groups and said this would be followed carefully.

(c) Doctor Quisling reviewed Bill 131, S. introduced at the request of the State Board of Health to permit those counties and cities having public health nurses to establish home care programs and to charge recipients of such services according to their ability to pay. The committee wished the Council's opinion on this legislation as a matter of policy.
After discussion, Doctors Hildebrand–Dessloch moved that the State Board of Health be advised that there are considerations in this bill which the Council feels have not been fully thought out, and ask if they will schedule it for further consideration with opportunity for Doctor Quisling and others to discuss it and try to reach agreement. Motion carried.

(d) Mr. Murphy was asked to present an analysis of legislation proposed by the chiropodists (podiatrists), following which Doctors Conway–Curran moved that the committee be directed to oppose this proposal in the form presented. Motion carried. Doctor Quisling said that the committee had scheduled a meeting with representatives of the podiatry group the following week to discuss it and see if agreed legislation can be arrived at.

(e) Doctor Quisling advised that several offices were interested in legislation for the control of radiation hazards but no bill had as yet been introduced, and that the Dental Society planned a modernization of the Dental Practice Act.

(f) He then reported subjects for legislation on which the Society, through the Committee on Public Policy, has filed "jackets" which must be "filled" by March 10:

(1) The committee has offered to assist the State Board of Medical Examiners in drafting legislation concerning the licensing of foreign graduates, the extension of the temporary licensing provision, direct authority to suspend a license or place a licensee on probation, and minor revisions concerning fees for certification of physical therapists.

(2) Consideration is still being given to suggestions that the Basic Science Board examination be expanded to permit the addition of chemistry and bacteriology.

(3) He said that appropriate committees and the staff had been working hard on legislation to implement the Kerr–Mills Act in Wisconsin, and that details would be presented later on.

(4) He indicated the possibility of legislation concerning more stringent educational requirements for the licensure of chiropractors in Wisconsin.

(5) The Division on Safe Transportation is to meet with Motor Vehicle Department officials on the implications of 1959 legislation which amended the definition of dangerous drugs so that it included all prescription drugs, and its effect on existing laws which might jeopardize a motor vehicle operator's license in the event he drives while under the influence of dangerous drugs.

(g) Other legislation which will have the Society's support on recommendation of interested committees is a joint resolution urging the use of seat belts in state operated motor vehicles, and requiring pre-employment examinations and periodic re-examinations for employees of schools of higher learning. Doctor Quisling also reported a bill which has passed both houses to permit a foreign physician to practice in Wisconsin.

5. Report of Commission on Hospital Relations and Medical Education

Doctor Gearhart reviewed material previously distributed to the Council relating to a further interpretation of Chapter 484, Laws of Wisconsin, 1959. The Guide circulated to all members was chiefly concerned with an interpretation of the revised fee splitting statute and its application to relationships between physicians and hospitals. The material now under consideration was intended to serve as a guide to the Commission in advising physicians making specific inquiry as to their relationships with other physicians in a partnership arrangement, a locum tenens, and the like. He stated that the Commission feels its function is to advise on legal implications of practicing arrangements between physicians, but since ethical considerations can also be involved in these situations, the Council was asked to give its approval to this further interpretive guide.

Doctor Fox reported that the Executive Committee of the Council had reviewed the material and recommended its approval.

On motion of Doctors Mason–Curran, carried, the Council approved it in principle.

Doctor Gearhart then summarized the proposed report of the Commission to the House of Delegates highlighting the subject just discussed and the further subjects of the need for medical students and its recommendations for a recruitment program; its efforts and recommendations in the area of post graduate education of interns and residents; and reference to the hospital achievement award program.

The annual report of the Commission was accepted by the Council.

6. Report of Commission on Medical Care Plans

Doctor Dessloch discussed a policy statement recommended by the Executive Committee for Council approval concerning cooperation with a commercial insurance company if it should install a "no fee schedule" type of contract. After discussion, the following statement was adopted on motion of Doctors Dessloch–Houghton, with the amendment shown in italics proposed by Doctors Fons–Egan:

> "The Commission on Medical Care Plans of the State Medical Society has long been sensitive to the possibility of other insuring organizations seeking to sell a surgical-medical contract in which the benefits are measured by the customary and reasonable charges of a medical community.
>
> This is the Special Service (no fee schedule) concept of the State Medical Society which has been available since 1955 and which was found to be a workable program under the auspices of the State Medical Society, using to the maximum the assistance of a local advisory committee.
>
> Administration of the Special Service concept is unique and some difficulties are not fully appreciated by the medical profession itself, and certainly not by the insurance industry. A decision with reference to the benefit to be paid under one set of circumstances is not necessarily a precedent for the benefit to be paid for an identical procedure but involving other circumstances, such as another medical community, a more complicated case, a longer period of hospitalization, etc.
>
> The State Medical Society considers that the problem of amount to be paid is essentially one existing between it and the physician, and that the beneficiary must not be embarrassed or concerned by delays that may ensue as a result of careful evaluation of some procedures, nor should the beneficiary feel that he may be the object of suit for additional fees, and to that end the State Medical Society agrees that if a patient should be sued by a physician, the Society will intervene as a party defendant to the action and will hold the defendant harmless of any liability; *providing that such action will be taken only after all means of the Society for mediation have been exhausted.*
>
> Neither is the Special Service concept one which can be confined to a specific geographic locality. In these days of easy modes of travel, employes of a group may very possibly receive treatment in various different areas of the country. The Commission on Medical Care Plans does not see any practical way for either the State Society or a county society to provide the administrative technique and involved details to other insurance organizations. This requires a concentration of effort and a continuity of purpose.
>
> However, should any insurance organization, duly licensed in Wisconsin, care to offer the Special Service contract of the State Medical

Society, the Commission on Medical Care Plans will cooperate in such manner that the insurance company and its appropriate employes be designated as special agents for such special purposes. In this capacity they would be in a position to offer the Special Service contract underwritten by WPS in conjunction with other elements of a health insurance "package." Any such arrangement would retain the autonomy of the medical profession, but permits insurance companies to offer the same device which the medical profession is providing in the public health interest."

7. Report of Commission on State Departments

Doctor Tormey presented the proposed report to the House of Delegates of the Commission and its various divisions, and answered questions from councilors on some of its recommendations.

Following discussion, the report was accepted on motion of Doctors Egan–Conway, carried.

8. Council Award

Doctors Fons-Hildebrand moved that a secret poll of the Council be taken on granting the Council Award to the physician nominated by Doctor Arveson before his death.

The nominee received a unanimous ballot.

9. Washington Trip

A recommendation of the Executive Committee had been communicated to the Council in January that a special committee of Society officials go to Washington to interview Wisconsin members of Congress and a number of representatives of federal agencies and voluntary associations concerned with public health.

After discussion, and on motion of Doctors Curran–Bell, carried, the delegation was authorized to make the trip as suggested, to be financed from surplus in the 1960 budget. The special committee was asked to make its initial report to the conference of presidents and secretaries scheduled for March 22.

10. Further Report of Executive Committee

(a) Report of President's Advisory Committee on Constitution and Bylaws, Structure and Administration of the State Medical Society. The committee reported its further review of this report and these reactions to some of the recommendations:

(1) It agreed that the title of the Committee on Public Policy be changed to the Commission on Public Policy.

(2) It disagreed with the recommendation that the Grievance Committee be enlarged, and felt that if anything, it should be reduced in size.

(3) It felt that it was unnecessary for a councilor to be a member of each Commission. It is the duty of the staff to provide liaison with the Council, and the Executive Committee finds no reason to depart from this procedure.

(4) It considered the suggestion that all committee appointments be cleared with county medical societies. It was felt that as a formal rule this was impractical.

(5) It felt that local option should govern on the question of dual office holding.

(6) It felt that the nominating committee should continue to function as it has in the past.

(7) It felt that creating further offices was not necessary in a voluntary organization. Although some councilors expressed differing opinions on several of the recommendations of the Executive Committee, they were accepted on motion of Doctors Dessloch–Conway, carried.

(b) Committee on Quackery

On motion of Doctors Houghton–Bell, carried, the Council approved the Executive committee recommendation that this committee, which has not functioned, be discontinued as there are ample committees now having jurisdiction of the subject.

(c) Council Meeting in Chicago

On motion of Doctors Curran–Dessloch, carried, the suggestion of Doctor Ekblad, recommended by the Executive Committee, was approved: that a future meeting of the Council be scheduled at AMA headquarters at an appropriate time.

(d) Committee on Federal Legislation

The Executive Committee recommended that this committee, created on somewhat of an emergency basis, now be continued as a permanent committee appointed as are other committees of the Council. It also suggested that its name be changed to the Committee on Health Economics of American Life (HEAL) as more indicative of its purpose.

On motion of Doctors Dessloch–Houghton, carried, the recommendation was approved.

(e) Service Corporation Legislation

Mr. Murphy reported the essence of legislation proposed by several professional groups to permit incorporation of one or more persons engaged in the provision of services so as to derive the tax and other benefits of such a structure.

On motion of Doctors Hildebrand–Dessloch, carried, support of such legislation was approved in principle, the mechanisms to be worked out through the Commission on Public Policy.

(f) Honorary Membership

On motion of Doctor Conway, variously seconded and carried, Amy Louise Hunter, M.D., was granted honorary membership in the State Medical Society.

11. Councilor District Reports

Doctor Fox called on individual councilors for a general report of conditions in their district.

The Council then recessed at 9:10 p.m., until 9:30 Sunday morning, February 26, when it convened as members of the SMS Realty Corporation for transaction of its annual affairs.

12. State Medical Society Budget for 1961

The Council reviewed in detail the budget recommended by the Finance Committee, summarized as follows: operating budget, $177,440 in normal accounts and $24,642 in special appropriations for conferences scheduled in 1961, officers' travel expenses, and promotional projects such as re-publication of the brochure on "Careers in Medicine and Health;" staff travel, payroll and related expenses, $157,024; or a total of $359,106.

On motion of Doctors Fons–James, carried, the budget was approved by the Council with an increase of $600 for consultant accounting services and $900 in the president's travel allowance for attendance at in-and-out-state meetings.

The Secretary's comments on 1960 operations were accepted, as were the recommendations that executive salaries not be considered until the May meeting, and that the Society contribute $15 to the Foundation on the death of a member as a mark of respect, with immediate notice to survivors.

13. Election of Officers

On separate motion duly made, seconded and carried, the following were nominated and unanimously elected to office for the ensuing year:

(a) James C. Fox, M.D., La Crosse, Chairman of the Council

(b) F. L. Weston, M.D., Madison, Treasurer of the Society

(c) H. Kent Tenney, M.D., Madison, Assistant Treasurer

(d) N. A. Hill, M.D., Madison, Assistant Treasurer

(e) C. H. Crownhart, Madison, Secretary of the Society and of the Council

(f) D. N. Goldstein, M.D., Kenosha, Editorial Director of the *Wisconsin Medical Journal*

(g) Victor S. Falk, M.D., Edgerton, Assistant Medical Editor, *Wisconsin Medical Journal*

14. Presidents and Secretaries Conference

The Secretary announced that Edward R. Annis, M.D. of Miami would be the principal speaker at the conference scheduled for March 22 and suggested that all councilors and officers, who could arrange to do so, plan to attend.

15. Adjournment

The Council adjourned at 11:30 a. m. on motion of Doctor Bell.

C. H. Crownhart
Secretary

Approved:

James C. Fox, M.D.
Chairman

SPECIALISTS AND GENERAL PRACTITIONERS

Available through Placement Service

The Placement Service of the State Medical Society has registered with it a number of specialists in various fields as well as general practitioners. Contact the Placement Service by writing Box 1109, Madison, Wisconsin.

HISTORY OF MEDICINE FILM AT MUSEUM

The film "69.3", a capsule story of the history of medicine, may be seen by visitors to the Museum of Medical Progress in Prairie du Chien, Wisconsin, from April 30 to November 1. The museum is a project of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin and is operated by the State Historical Society.

Chosen for showing at the White House Conference on Aging, "69.3"—narrated by Alistair Cooke and sponsored by Pharmaco, Inc. and White Laboratories, Inc.—pays tribute to all those scientists, physicians, pharmacists and nurses who have dedicated themselves to overcoming superstition, bigotry, and ignorance. Their achievements—the average life expectancy of "69.3" is related in the exciting story of medical progress from caveman to the present Golden Age of medicine.

THE MEDICAL FORUM

Legislative Session Moving In High Gear With Kerr–Mills Proposal A Major Item

Chiros Alter Measure Seeking More Support

Kerr–Mills implementation in Wisconsin continues as one of the major items before the legislature this session.

Bill 550, A.—which would establish the Wisconsin Health Assistance Act for the aging—received its preliminary hearing before the Assembly Public Welfare Committee on May 9.

A companion bill in the Senate, Bill 466, S., has been referred to the Joint Finance Committee.

The main hearing on Kerr–Mills legislation is expected to come before the Joint Finance Committee at a future date.

A third bill on the subject, Bill 630, A., has also been introduced.

The State Medical Society, preferring the proposals of Bills 550, A. and 466, S., continues to work with public and voluntary agencies on a more refined bill.

Meanwhile, in a move which contradicts their own definition of chiropractic, the chiropractors have brought about amendment of Bills 340, A. and 249, S.—dealing with Workmen's Compensation—which would limit payment of their services to injuries of the spine and pelvis.

Sensing almost unanimous opposition to their original proposal to include all chiropractic procedures under the act, the new amendment is a move to gain support of other groups.

To the medical professional it points up the need for continued active opposition to the two bills. Both have had hearings at this point.

Legislative Status Report

(as of May 26, 1961)

ALCOHOLISM

Bill 170, A. by Belting establishes Governor's Commission on Alcoholism. Passage recommended by Assembly Committee on Public Welfare; now before Joint Finance Committee. SMS supports.

OPTOMETRY

Bill 188, A. by R. E. Peterson expands powers of Board of Examiners in Optometry on matters relating to advertising, etc. but limits its powers concerning the practice of optometry and opticianry. Passed both Houses. SMS no objection as amended.

(Continued on page 356)

Chiropody Bills Pass Assembly Despite SMS Plea For Delay

Three bills on Chiropody—of great importance to Wisconsin medicine—have passed the Assembly and now await Senate action.

The bills are as follows:

Bill 345, A. by Molinaro designates chiropodist as "physician" to permit him the use of narcotics. This is similar to Bill 391, S.

Bill 490, A. by Molinaro permits chiropodist use of drugs and medical treatment of the foot and surgical treatment of the foot except for major surgery. This is similar to Bill 390, S.

Bill 346, A. by Molinaro authorizes payment of chiropody services under Public Assistance Laws, and was recommended for passage by the State Medical Society.

Passage of the first two bills listed above came in spite of a State Medical Society plea that the Assembly postpone both of them until an evaluation of a chiropodist's training is available.

A letter sent to all Assemblymen, and two of the enclosures, are printed elsewhere in this issue of the *Forum.*

THE STATE MEDICAL SOCIETY OF WISCONSIN
330 EAST LAKESIDE STREET • MADISON 5, WISCONSIN • ALpine 6-3101

May 22, 1961

TO THE HONORABLE
MEMBERS OF THE ASSEMBLY

The State Medical Society respectfully urges:

Indefinite Postponement of Bill 345, A.

Passage of Bill 346, A.

Indefinite Postponement of Bill 490, A.

In making these recommendations, the State Medical Society does not oppose podiatry. It does not seek to jeopardize the practice of the podiatrist or his useful service to the public. On the contrary, the Society energetically seeks to establish an agreed basis for podiatry's rightful role in health care.

However, the requested rights to use and prescribe narcotic drugs and engage in "medical" care contemplated by Bills 345, A. and 490, A., are of genuine concern:

....Podiatrists do not take the Basic Science examination as do other practitioners, even some who are not permitted the use of drugs.

....The necessity of caution in granting authority to prescribe the dangerous drugs and narcotics is evident from General Circular No. 259 issued by the Federal Commissioner of Narcotics on April 20, 1961. It should be noted that page 7 lists exempted preparations which are available to podiatrists.

....Nationwide, the podiatrists' privileges in hospitals, and especially the use of drugs, are limited by virtue of their training (see attached statements of policy).

....With only 155 podiatrists in Wisconsin, 70 of whom are in one county, the matter is not of major urgency to the health of our population.

Now it may be that the podiatrists should be privileged to use dangerous drugs. The determination must be based on education and training, not emotional appeal. And not enough is known of podiatry education at this time.

That is why the Medical Society has asked for an early and thorough study of podiatry education and practice.

The American Podiatry Association itself is in the process of having inspection teams of physicians, educators and scientists evaluate the training of podiatrists and the standards of their five schools.

The results of these studies should be available before the next session of the Legislature two years hence, and should serve as a guide to its members.

It is for these reasons, and in full recognition of the value of podiatry in the total health care picture, that the State Medical Society urges the Legislature to "go slow" with these bills.

Sincerely yours,

Earl R. Thayer
Assistant Secretary

ERT:mjn

Enclosures

A Statement Of Policy

of the

AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

on the practice of

Podiatry In Hospitals

1. There is a place for podiatrists in hospitals.

2. The extent of podiatry service should be determined at the local level and vary with the size, type, staff organization of, and service rendered by the hospital.

3. These services should logically be provided in the Out Patient Departments of those hospitals in which podiatrists are permitted to practice and be confined within the scope of the practice of podiatry as authorized by the statutes of the state.

4. The services of podiatrists in hospitals are in the best interest of the public only when rendered under medical supervision and should be confined to the Out Patient Department.

5. The services of podiatrists in hospitals must be rendered under one of the existing Departments or Sections which has been charged with the supervision of podiatry services. Provision of podiatry services in the hospital does not confer on podiatrists the privilege of admitting patients to the hospital.

6. In those hospitals where a podiatrist is permitted to perform surgery as a technician, it is recommended that he be under the direct supervision of a physician. By supervision, it is meant that during the operation, a staff surgeon must be present in the operating room, gowned and scrubbed, as the responsible person.

7. The podiatrists in their relationships with physicians should subscribe to and comply with "Guiding Principles for Relations Between Physicians and Allied Health Professions" as recommended to the A.M.A. by the Committee on Relationships of Medicine with Allied Health Professions and Services, and as adopted by the House of Delegates of the A.M.A., June 16, 1960.

(April 15, 1961)

HAVE YOU LOOKED AT YOUR INCOME PROTECTION LATELY?

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Internship Problems Discussed At Conference

Problems relating to internship programs were discussed May 20 at a day-long conference sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society in Madison.

Seventy-five representatives of hospitals, medical staffs, the state's two medical schools, State Medical Society and the American Medical Association participated in the discussions.

Speakers were:

Dr. Leland S. **McKittrick**, Boston, Mass., chairman of the Council on Medical Education and Hospitals, American Medical Association.

Dr. James **Campbell**, Chicago, a director of the National Intern Matching Program and member of the AMA Council on Medical Education and Hospitals.

Dr. Richard Saunders, Jr., New York City, associate dean of Cornell University Medical College.

George E. **Cartmill**, Jr., Detroit, director of Harper Hospital.

The crux of the situation was summed up in two statements:

The first by Doctor Campbell: "The national intern matching program is merely a clearing house trying to assist the students and hospitals . . . It can't make 6,000 students fit into 12,000 internships."

The second, by Doctor McKittrick: "I know that with few exceptions the fellows want to go where they can learn the most the fastest . . . You can have a program high in service but without education; but you cannot have a good educational program that is not high in service."

For Wisconsin, the problem of attracting interns is one-third of an overall situation affecting the future level of medical care in the state. The other two: a decreasing number of qualified applicants to medical schools and the number of Wisconsin-educated physicians who move to other states to establish practices.

The out-of-state speakers pointed out that most other states share the same problems.

A MAIN SPEAKER at the Conference on Internship Programs held May 20 at the State Medical Society headquarters in Madison was Dr. Leland S. McKittrick, Boston, Mass. Doctor McKittrick is chairman of the Council on Medical Education and Hospitals of the American Medical Association.

What do interns want?

According to Doctor Saunders, the main requisites to the intern are:

1. Broad patient exposure.
2. More responsibility for patient management.
3. Close association with the senior staff.

Can a hospital with private patients and a staff of private practitioners conduct a good internship program?

The answer by Doctors McKittrick and Campbell was "Yes."

(Continued on page 355)

Resolution On Chiropody

The laws of the various states are not uniform in their definition of chiropody and its scope of practice. This becomes a matter of public health interest, particularly since "Hospital Accreditation References," a publication of the Joint Commission on Accreditation of Hospitals and the American Hospital Association, 1959, states:

"A hospital staff may vote a chiropodist privileges in his specialty. Each hospital staff must evaluate the chiropodist who applies for hospital privileges and set up qualifications, rules and regulations.

"Chiropodists must be under the jurisdiction of the department of surgery. A physician must be in attendance when the chiropodist is operating in the hospital on an inpatient. Where minor outpatient podiatry is performed, it will be done under the supervision of the surgical department although actual attendance is not required. The chiropodist is in the nature of a technician, functioning under the surveillance and supervision of a physician.

"The chiropodist is not qualified to write the history or physical examination nor check the heart and lungs before an anesthetic. This applies also to prescribing drugs both preoperatively and postoperatively in the hospital.

"The podiatric patient must be admitted to the hospital under the physician's name. The chiropodist cannot and does not have the privilege of admitting a patient under his own name.

"It is in no way obligatory that a chiropodist be given privileges. It is up to each individual hospital staff to evaluate the hospital's needs, the individual's qualifications and competence, and then vote on the matter with recommendations to its board of trustees. The board of trustees of any hospital, before giving approval to such election, should make sure that the hospital's bylaws, rules and regulations spell out all facts and privileges."

Resolved, That this House of Delegates request its delegates to the American Medical Association to seek a thorough review and study of chiropody by the AMA for the purpose of establishing agreement as to its definition, the scope and quality of its education, and uniformity as to its standards of practice; and be it further

Resolved, That this resolution be transmitted promptly to the AMA Board of Trustees and to its Executive Vice President with a request for early implementation.

Adopted May 2, 1961, by the House of Delegates, State Medical Society of Wisconsin

CONFERENCE ON INTERNSHIP participants were, left to right: Dr. Robert S. Gearhart, Madison, chairman of the Commission on Hospital Relations and Medical Education of the State Medical Society; Dr. Richard Saunders, Jr., New York City, associate dean, Cornell University Medical College, and Dr. Walter Wiggins, secretary of the Council on Medical Education and Hospitals of the American Medical Association.

Internship Problems Discussed

(Continued from page 354)

"But every hospital cannot and should not want to have such a program," Doctor Campbell added.

What about the danger of losing approval of the internship program if a sufficient number of positions are not filled?

Doctor Saunders pointed out that an institution would have to obtain less than 25% of its stated complement of interns for two years in a row before being in danger, "so you really have to be striking out to lose approval."

Speaking from the hospital administrator's viewpoint, Mr. Cartmill said, "A hospital must make up its mind that education is a basic function, and not just incidental."

"A hospital unwilling to make this decision should take a good look at whether it should have an internship program," he added.

What about hospitals unable to attract sufficient interns or operate an internship program?

Looking strictly at the service factor, Doctor McKittrick suggested the development of ancillary personnel, similar to the wartime hospital corpsman, "trained to do one job, and do it well."

How can a hospital attract interns?

Although some examples of successful recruiting procedures were mentioned, the consensus was that the most dependable answer was a good internship program with the educational and service factors in proper perspective.

Following each section of the conference, a Wisconsin discussant, familiar with that phase of the internship program, commented on the speaker's remarks. This was followed by question and answer periods.

Twenty-one Wisconsin hospitals offering internship programs were represented at the conference. It was sponsored by the State Medical Society, through its Charitable, Educational and Scientific Foundation, in cooperation with the Council on Medical Education and Hospitals of the American Medical Association. Support was provided by the Red Arrow Sales Corporation of Madison.

Doctors Talk To Counselors At UW Meet

Dr. John Z. Bowers will address a conference of guidance counsellors on the topic "Medical Students—Their Preparation, Their Selection and Career Opportunities" on June 29 in Madison.

Approximately 700 guidance counselors are expected to attend the two-day session, which also includes talks by Professor W. Max Wise of Columbia University and Miss Evelyn Murray, Chief of Youth Services in the Department of Labor.

Serving on a reactor panel following Doctor Bowers' talk will be Dr. Robert S. Gearhart, Madison; Dr. T. H. McDonell, Waukesha; Dr. David W. Smith, Madison, Dr. R. F. Lewis, Marshfield, and Jerome Gundersen, medical student at the University of Wisconsin.

Doctor Gearhart is chairman of the State Medical Society Commission on Hospital Relations and Medical Education; Doctor McDonell is chairman and Doctors Smith and Lewis are members of the Commission's subcommittee on medical student recruitment.

MADISON VA HOSPITAL GIVEN SAFETY AWARD

The Veterans Administration hospital at Madison placed second in the 1960 hospital safety contest for VA hospitals in the 450–600 employee category, according to an announcement by the Veterans Administration.

The contest was sponsored by the American Hospital Association and the National Safety Council.

PROFESSIONAL BUSINESS SERVICE
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La Crosse, Wisconsin

Business Consultants to the Medical Profession.

Inquiries Invited

Physicians Aid In State Crash Injury Study

The Council of the State Medical Society has agreed to participate in a study of the causes of injury and death in rural auto accidents in Wisconsin.

The study, to be conducted by a research group from Cornell University, will start in the state July 1.

Purpose of the project is to collect data on specific causes of injury to occupants of passenger autos, and to bring about changes in auto design to eliminate these causes.

The study is sponsored by the Wisconsin State Patrol and the State Board of Health, and has been approved by the Wisconsin Hospital Association and the State Medical Society.

Under the plan, state highway patrol officers record the accident details, injury causes and information on damage to the cars involved and also take special photographs.

When an occupant of a passenger car is killed or injured in an accident in the sampling area, the investigating State Patrol officer will bring to the hospital, or private physician treating the patient, a special medical form bearing the patient's name. The physician will complete the form and return it directly to the State Board of Health.

Medical reports are matched by the State Board of Health with the State Patrol officer's data. At this time the names of the patient and the physician are detached from the form and destroyed to insure strict confidentiality, and the case histories are then forwarded to Cornell for analysis and statistical use.

A two-year study is planned in Wisconsin. For the first six months, injury producing rural auto accidents in approximately the eastern half of the state will be reported. Investigations in the second six months will be in roughly the western half of the state.

In the second year the entire state will be covered, but only injury-producing rural accidents involving autos manufactured in the last four years will be included.

Monroe Evening Times

A MEDICAL–LEGAL CLINIC, to familiarize lawyers with medical fundamentals involved in accident and compensation cases, was held April 29 in Monroe. Above Philip S. Habermann, executive director of the State Bar of Wisconsin, and Dr. Robert Zach, program moderator, discuss the event which attracted more than 80 lawyers from southern Wisconsin.

Status Report On Legislative Bills

(Continued from page 351)

CHIROPRACTIC

Bill 340, A. by Ward, et al., provides for payment of chiropractic services under Workmen's Compensation Act. Chiropractors have introduced an amendment limiting payment of their services to injuries of the spine and pelvis. **Bill 249, S.** is the similar Senate bill. Hearings held on both bills. SMS opposed.

HOSPITAL DRUG ROOMS

Bill 344, A. by Molinaro would require registration of hospital drug room by State Board of Pharmacy and the supervision of these drug rooms by registered pharmacists. Hearing before Assembly Judiciary Committee. SMS opposed.

CHIROPODY

Bill 345, A. by Molinaro designates chiropodist as "physician" to permit him the use of narcotics. Similar to **Bill 391, S.** Bill passed Assembly; now in Senate. SMS opposed.

Bill 346, A. by Molinaro authorizes payment of chiropody services under Public Assistance Laws. Passed Assembly and now in Senate. SMS no objection.

Bill 490, A. by Molinaro permits chiropodist use of drugs and medical treatment of the foot and surgical treatment of the foot except for major surgery. Similar to **Bill 390, S.** Passed Assembly and now in Senate. SMS opposed.

KERR–MILLS IMPLEMENTATION

Bill 550, A. by Quinn, et al., sets up Wisconsin Health Assistance Act for the aging to carry out provisions of Kerr–Mills Act for federal-state program to meet health care needs of certain of the elderly. Similar to **Bill 466, S.** by Morton, et al. Heard by Assembly Public Welfare Committee and Senate bill referred to Joint Finance Committee. SMS supports.

Bill 630, A. by Molinaro relates to same subject, but SMS prefers the proposals of 550 A. and 466 S.

SMS continues working with public and voluntary agencies on a more refined bill.

(Continued on page 357)

Plan Television Program Of Family Physician On NBC Network June 27

A revealing story of the life of a family physician will be presented on the NBC television network Tuesday night, June 27, in conjunction with the annual meeting of the American Medical Association in New York.

Entitled "Doctor B," the hour-long program shows a typical day in the life of a physician.

In Wisconsin the program is expected to be carried by WTMJ–TV, Milwaukee; WMTV, Madison; WKBT, Green Bay from 9 to 10 p.m.

Plan Summer Programs For Visually Handicapped

Two summer programs have been announced by the Wisconsin School for the Visually Handicapped at Janesville.

An institute for the parents of pre-school blind children will be held August 13–20. Primary objective is to help the parents prepare the child for school and life.

The summer school for Adult Blind is scheduled from July 1 through August 11, with the objective of helping the adult blind who have lost vision after secondary school age.

(Continued from page 356)

AGING

Bill 267, A. by Huber, et al., establishes State Commission on Aging. Similar to **Bill 202, S.** Passage of both bills recommended by Assembly and Senate Committees on Public Welfare and referred to Joint Finance Committee. SMS supports.

PERSONAL SERVICE CORPORATIONS

Bill 587, A. by Pommerening permits physicians and other self-employed professionals to establish tax deferred retirement income programs. Referred to Committee on Taxation. SMS supports.

RADIATION CONTROL

Bill 600, A. by Pommerening, et al., establishes registration of radiation sources and nuclear development office. Heard in Judiciary Committee.

Bill 623, S. by Cameron and Zaborski establishes registration of radiation devices in State Board of Health. Referred to Senate Public Welfare Committee.

PUBLIC HEALTH

Bill 2, S. by the Legislative Council replaces town health officer with county health director and commission. Permits village and city to keep health officer if they wish. Heard by Senate Public Welfare Committee. SMS supports.

Bill 3, S. by the Legislative Council permits cities and counties to jointly arrange financing method for county health departments. Heard by Senate Public Welfare Committee. SMS supports.

Bill 335, A. by Quinn establishes 15 member advisory committee to the State Board of Health on local health services. Similar to **Bill 295, S.** by Cameron. Assembly Public Welfare Committee recommends passage of **335, A.** Referred to Joint Finance Committee. **Bill 295, S.** still in Senate Public Welfare Committee. SMS supports.

HOME NURSING CARE

Bill 131, S. by Bice authorizes city and county health departments to establish home nursing care programs on a fee basis utilizing public health nurses. Senate Public Welfare Committee has recommended passage but introduction of amendments has resulted in re-referring to the Committee. SMS opposed.

PHYSICAL EXAMINATIONS

Bill 197, S. by Bice requires pre-employment and periodic physical examinations for college employees. Passed Senate and now in the Assembly Education Committee. SMS supports.

Plan Meeting On Disaster Medical Care

The Twelfth County Medical Socities Conference on Disaster Medical Care will be held November 4–5 at the Palmer House in Chicago, under sponsorship of the American Medical Association.

Each county medical society and state medical society is invited to send at least one representative to the conference.

One symposium will be devoted to "The County Medical Society and Disaster Medical Care." Topics will include: objective, purpose and organization; relationship of county and state societies in disaster planning; educational and training programs; mutual aid in large-scale disaster—county and state concepts; health mobilization in total warfare; and rural medical support for target area disaster.

A second symposium will include pertinent topics under the general heading of "Training of Allied Health Professions and Services."

Specific details on the program will be forthcoming at a future date.

On November 4, eight regional workshop sessions will be held so that those attending the conference can discuss mutual problems and suggestions to overcome the problems.

DR. DORCHESTER NAMED TO MIGRANT COMMITTEE

Dr. Daniel E. Dorchester, Sturgeon Bay, has been appointed to the Governor's Committee on Migratory Labor.

The committee works for improvement of the social, economic, educational and health status of the more than 10,000 migrant workers who come to Wisconsin each year.

It also works closely with the President's Committee on Migratory Labor.

Doctor Dorchester, a member of the Commission on Public Relations and Communications of the State Medical Society, brings to the committee a background of activity on behalf of the migrant workers in the Door County area and on a statewide basis.

Report Status Of SMS Life Insurance Plan

The Life Insurance Plan of the State Medical Society, available through arrangements with the Bankers Life Company of Des Moines, Iowa, reports a total of $5,817,500 of insurance in effect for 583 Wisconsin physicians as of March, 1961.

The insurance, available to member physicians outside Milwaukee county, involves an individual $10,000 term insurance policy for those below age 60, and a $7,500 policy for those between 60 and 64.

Since November, 1957, four physicians covered by the program have died, with the survivors collecting a total of $40,000 in benefits.

Of the physicians now covered, 546 have the term insurance and 37 carry permanent insurance, available under a conversion provision.

Elroy Leader–Tribune

ST. JOSEPH'S MEMORIAL HOSPITAL in Hillsboro received one of the two Hospital Achievement Awards presented this year by the State Medical Society. Pictured above at the presentation ceremony are, left to right: Dr. T. E. Boston, Hillsboro, former chief of the medical staff at the hospital; Dr. James C. Fox, chairman of the Council who made the presentation; Reverend Mother Joan of St. Rose Convent, La Crosse, Superior General of the Franciscan Sisters of Perpetual Adoration, operators of the hospital; Sister Mary Gregory, administrator of the hospital; Dr. H. P. Baker, Wonewoc, member of the medical staff, and Dr. Roy Balder, Jr., Hillsboro, chief of the medical staff.

Racine Journal–Times

ST. LUKE'S HOSPITAL IN RACINE was selected to receive a 1960 Hospital Achievement Award of the State Medical Society. Above, right, is Dr. L. H. Lokvam, who made the presentation. William Naleid, vice-president of the hospital board of directors, and Dr. Beatrice O. Jones, chief of the hospital's medical staff, examine the award.

Change Announced in VA Home Town Care

Starting July 1, 1961, the Veterans Administration will in some cases send an IBM card to renew treatment authorization under the Home Town Care Program for the fiscal year beginning on that date.

This type of renewal will apply to veterans now under treatment where the service-connected disability is accurately stated on the present authorization, and the estimate of outpatient treatment required is not at great variance with the veteran's need.

Physicians treating more than one patient under the VA program could receive both the IBM card renewal and the conventional authorization form.

Physicians authorized to treat veterans are asked to provide treatment for service-connected disabilities according to the veteran's need, the announcement stated. A bill and treatment report should be sent to the Veterans Administration, Regional Office, 342 North Water Street, Milwaukee 2, Wis., once each month. A check for approved services will be issued once a month, with a listing of patients' names, the amount paid for each, and an identification of the month service was rendered.

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Prevention and Treatment of Adrenal Insufficiency During Surgical Procedures

By MAXWELL WEINGARTEN, M. D., and W. PHILIP G. JONES, M. B., Ch. B.

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ANY SURGICAL procedure may initiate a complex series of biochemical changes in the body which have been variously described as "the reaction to trauma," "the metabolic response to surgery" and "the stress-adaption syndrome." The fundamental function of these changes is the rapid restoration of the pre-existing homeostatic equilibrium which has become disturbed and disrupted by the stress of the operation and anesthetic. This process involves the activation and interaction of numerous neurohumoral mechanisms involving the hypothalamus, pituitary, adrenals and autonomic nervous system.

Estimation of the Stress Response

One of the accepted parameters for the assessing of the body's ability to withstand stress is the functional reserve capacity of the adrenal cortex to produce increased amounts of the steroid hormone hydrocortisone. The main actions of this corticosteroid appear to be the maintenance of blood pressure and the regulation of the water and sodium content of the body fluids.

During and after surgical operations the circulating level of hydrocortisone must be increased above the preoperative level if the above homeostatic functions are not to be compromised. In certain patients, due to disease, surgical ablation of the pituitary and adrenal glands or the therapeutic administration of steroids, the adrenal cortex is unable to elaborate the necessary increased amounts of the hormone. These patients are thus in a state of limited adrenocortical reserve, being unable to undergo one of the normal metabolic responses of the adrenal cortex to stress by increasing their output of hydrocortisone.

It must be emphasized that the metabolic response to surgery is not solely the result of changes in the output of steroids by the adrenal cortex. However, a normal metabolic response is not possible unless these changes occur.

The deficit of circulating hydrocortisone may give rise to serious problems during the course of operation and in the postoperative period. However, there is good clinical and experimental evidence that many of these patients can be helped through their period of surgical stress by the administration of exogenous steroids and other supportive measures. Thus their early recognition, preferably prior to operation, becomes a matter of some importance and concern.

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Recognition of Limited Adrenocortical Reserve

During the preoperative assessment of the patient the following findings should arouse suspicion that a condition of incipient adrenocortical insufficiency may be present:

Previous therapeutic administration of corticosteroids—Treatment with these compounds produces atrophy of the adrenal cortex through pituitary inhibition of ACTH production. The adrenal reserve is thus diminished so that when stress occurs the output of steroids is not increased.

It is not known for what period steroid therapy must be continued before there is significant diminution in adrenal reserve capacity, or for how long function remains inadequate after cessation of treatment. As a clinical rule it may be assumed that any patient who has received steroids for a period of one week or more has diminished function and that this can persist for up to six months after they have been discontinued.

Pituitary and adrenal disease—Apart from adrenal cortical atrophy (Addison's disease) such conditions as panhypopituitarism, functioning adrenocortical tumors and the adrenogenital syndrome may be associated with adrenal insufficiency. Insufficiency may also follow the surgical ablation of pituitary and adrenal tissue.

Abnormalities of body pigmentation—As a general rule the primary adrenal insufficiencies exhibit increased pigmentation while those secondary to pituitary failure show the reverse with areas of depigmentation.

Severe fulminating acute illness or prolonged chronic disease—In these conditions exhaustion atrophy of the adrenals can occur. Adrenal exhaustion may also be seen in persons who show marked anxiety preoperatively and in debilitated patients who have undergone recent, multiple operative procedures.

Weakness, easy fatigability and hypotension—These findings may be indicative of a limited adrenocortical reserve. Other suggestive stigmata include persistent hypotension during and after previous surgery not due to unreplaced blood loss and refractory to vasopressors. There may be delay in the return of consciousness following general anesthesia and the patient sometimes volunteers that he went into "shock" following a previous minor operation.

Prolonged anticoagulant therapy—On rare occasions this may lead to a hemorrhagic destruction of the adrenal gland.

Laboratory Tests

Numerous tests of varying degrees of usefulness may be performed to confirm or refute a clinical impression of possible adrenal insufficiency. An estimation of the degree of adrenocortical responsiveness may be made by the measurement of the urinary output of corticoids and 17-ketosteroids and the response to intravenous corticotropin.

However, in many cases, the results of these tests can be misleading due to the multiplicity and variability of factors which may affect steroid synthesis, conjugation, excretion and tissue utilization. For this reason we consider the clinical evaluation of the patient to be of the greatest importance; the ancillary laboratory investigation being an adjunct of limited value.

Prevention of Adrenal Exhaustion During Operation

Those patients whose clinical examination and laboratory investigation indicate the possibility of incipient adrenocortical insufficiency require careful management to mitigate against the possibility of developing acute adrenal exhaustion.

The aim of treatment is to avoid taxing the already diminished adrenal reserve. This is done by the therapeutic administration of sufficient exogenous steroid to enable the body to combat the additional stress imposed by the surgical procedure.

A suitable regimen is as follows. On the morning of surgery give 100 mg. of cortisone acetate intramuscularly. During the operative procedure give 100 mg. hydrocortisone intravenously in 500 ml. of 5% dextrose in normal saline, repeating this every 8 hours throughout the day of operation.

On the first postoperative day give 150 mg. of cortisone intramuscularly. This is reduced on succeeding days to 75 mg. and 50 mg. The dosage is then gradually reduced over the next few days. It is advisable to give ACTH with the cortisone for the last 2 or 3 days of therapy, tapering off the dosage as the amount of cortisone is decreased. This boosts adrenocortical activity which may have become inhibited by the exogenous steroid administered.

A satisfactory schedule consists of ACTH 15 units initially, reducing to 10 and 5 units on succeeding days.

Sudden Acute Adrenal Insufficiency

Sudden acute adrenal insufficiency may become manifest during the course of operation or in the immediate postoperative period. The most common finding is a persistent, unexplained hypotension which is refractory to treatment by vasopressors and adequate blood replacement. It must be emphasized that an "unexplained" hypotension is one in which a careful and exhaustive search has been made to exclude the many other causes of a low blood pressure.

If the hypotension is associated with an elevated temperature, a normal or only slightly elevated pulse rate and the presence of eosinophils in a smear of the peripheral blood, then the patient should be assumed to have an acute adrenal insufficiency necessitating immediate treatment.

Treatment

Hydrocortisone 100 mg. is given intravenously at once and then every 8 hours for 3 doses. This is then followed on the first postoperative day by cortisone 100 mg., gradually tapering off the dose on succeeding days as described in the prevention of adrenal exhaustion. Before completely weaning the patient off cortisone, ACTH is given additionally for a few days as previously mentioned.

Large amounts of dextrose are essential for these patients as the adrenal insufficiency can produce disturbances of intermediary metabolism. The liver and muscle glycogen become depleted, breakdown of carbohydrate is increased and hypoglycemia may occur. The hyponatremia and dehydration consequent upon failure to conserve sodium ions must also be corrected. A solution of 10% dextrose in normal saline, 1,000 ml. to 2,500 ml., is given intravenously over the first 24 hours, care being taken to avoid circulatory overloading. Requirements on succeeding days are determined by the fluid intake and output and the electrolyte balance.

Persistent salt loss in the postoperative period may occasionally necessitate administration of a salt-retaining steroid preparation such as desoxycorticosterone or fluorohydrocortisone.

If the intravenous infusion of hydrocortisone and dextrose in saline fails to rapidly restore the blood pressure, one of the more powerful vasopressors such as levarterenol bitartrate (Levophed) or phenylephrine (Neo-synephrine) is given intravenously. It must also be remembered that if the patient has received large amounts of therapeutic steroid prior to surgery, as in the treatment of certain collagen diseases, the body tissues become habituated and refractory to its effects. In these cases, very large doses of hydrocortisone of up to 1,000 mg. intravenously, may be required.

The presence of any latent, overt or suspected infectious process is an indication for appropriate antibiotic therapy, initially by the intravenous route.

Due to the possibility of steroid-induced acute peptic ulceration, a suitable anti-ulcer regimen is maintained for the duration of steroid administration.

During the period of surgical convalescence, the patient is given a thorough endocrinological work-up to exclude any state of continuing adrenal insufficiency which may necessitate permanent maintenance on steroids. Before discharge the problem is carefully explained to the patient and any responsible relatives so that they may forewarn those concerned if any surgery becomes necessary in the future.

Summary

The clinical detection of latent adrenocortical insufficiency states and their management during surgical procedures has been described. The diagnosis and treatment of sudden, acute adrenal failure during the course of operation or in the postoperative period has been discussed. The rapid parenteral administration of steroid preparations may be a life-saving procedure in these patients.

3310 West Kinnickinnic River Parkway (15).

REVISED PROCEDURES IN BICILLIN PROGRAM

The Bureau for Handicapped Children of the State Department of Public Instruction wishes to announce that beginning July 15, 1961, new policies and procedures covering the administration of the statewide oral Bicillin program will be in effect. At the suggestion of the House of Delegates of the State Medical Society of Wisconsin and with the advice and cooperation of the Division on Handicapped Children of the Society's Commission on State Departments, the Bureau for Handicapped Children will no longer require that children be examined at a heart clinic or by a specialist in order to be enrolled in the permanent Bicillin program. While attendance at a heart clinic is no longer mandatory, the House of Delegates and the Bureau for Handicapped Children strongly urge that physicians *voluntarily* make use of the Wisconsin Heart Association Clinics or the special clinics in Madison.

In setting up the revised procedures, the Bureau for Handicapped Children wishes to emphasize that the Bicillin program, whereby oral Bicillin is available at the reduced rate of 5¢ per tablet, is designed to assist only those *families in financial need.* In order to determine whether a family is financially eligible for the Bicillin at the reduced rate, the Bureau for Handicapped Children will require completion of a financial eligibility form by the family, which is in keeping with all other programs of the Bureau where funds are available on the basis of financial need.

The Bureau for Handicapped Children also wishes to point out that this program is designed for prophylaxis and on that basis a maximum of two Bicillin tablets daily will be supplied. It is not possible through this program to supply medication for treatment of an acute condition.

Each physician who presently has children enrolled in the Bicillin program will be sent a letter informing him of the revised procedures. The new registration forms will not be required on children already enrolled in the permanent program. However, completion of a financial eligibility form will be required of each family currently on the program. A letter explaining this procedure will be sent to each family, together with a financial eligibility form. Six month follow-up reports will be required in the future for all new patients and all patients currently on the program. The data provided on the registration form and on the follow-up forms will be used to compile statistical data regarding the incidence of rheumatic fever and rheumatic heart disease, recurrent attacks of rheumatic fever and development of bacterial endocarditis. These data will be necessary to justify continuation of this type of program. Physicians requesting Bicillin under this program will be expected to provide all the information requested on the forms.

Procedures to be Followed in Obtaining Medication

1. Under the new procedures, any licensed physician in Wisconsin desiring to register his patient for the reduced rate Bicillin may request an application form by writing directly to the Bureau for Handicapped Children, 122 West Mifflin Street, Madison, Wisconsin. This form, based on the modified Jones Criteria, when properly completed by the physician, serves as a report of the case.

2. A financial eligibility form will be sent to the physician at the same time the application form is sent. If he feels the family may qualify for the reduced rate, he may encourage the family to fill in the form and return it directly to the Bureau for Handicapped Children.

3. Upon receiving the application form from the physician and the financial eligibility form from the family, the Bureau for Handicapped Children will determine whether the family is eligible for enrollment in the reduced rate program. The physician and the family will be notified as soon as possible of this decision. If the family is eligible, they will be requested to send their check to cover a six months' supply. If the Bureau finds the family cannot pay even the reduced rate, the Bureau for Handicapped Children will authorize payment.

4. Each child enrolled in the program will be referred to his local public health nurse.

5. No more than a six-month supply of Bicillin will be sent to the patient at one time. The Bureau for Handicapped Children will request additional information from the physician on each case before the six months have elapsed in order that the prescription can be refilled and the medication continued, if considered necessary. These follow-up forms will be sent directly to the physician when due by the Bureau for Handicapped Children.

Isoniazid Medication in Tuberculin Reactors of All Ages: a New Pattern in Prophylaxis of Childhood Tuberculosis

A Preliminary Report

By KARL E. KASSOWITZ, M.D.

Milwaukee, Wisconsin

THE PROBLEM of tuberculosis, as an almost ubiquitous pandemic, has been narrowed to a search for effective preventive measures to eliminate the yet too numerous sporadic cases. To help solve this basic problem, both diagnostic and prophylactic measures are utilized.

There is still general agreement on the sound value of the tuberculin test as a case finding, as well as case excluding, means especially in children, notwithstanding the recent demonstration by Palmer[1] of occasional nonspecific cross reactions.

Tuberculosis prevention may be divided into primary and secondary prophylaxis. Primary prophylaxis consists of (1) drying up the potential adult sources of infection, (2) active immunization (B.C.G.) before exposure, (3) antibacterial medication (isoniazid) before exposure. Secondary prophylaxis may be employed after the human host has been challenged by the bacterial invader.

For practical purposes, primary prophylaxis involving the use of isoniazid before exposure can be discounted because, according to animal experiments, it has been found to interfere with the desirable allergic and immunologic responses.

Secondary prophylaxis, involving the administration of isoniazid in subclinical infections, is now a generally accepted procedure. Since Lincoln[2] published her observations (1954) that INH-treated Mantoux-positive children did not develop meningitis, the arguments about the practical use of the drug have revolved around the questions of age, time of conversion, length of treatment and reconversion to negative.

Based on the opinions of the different authorities in this field, a case can be made either for or against any limitation as to age. Instead of quoting the many controversial opinions found in the literature, we will refer only to two recent authoritative publications on this topic: (1) Panel on Chemoprophylaxis of Tuberculosis, Philadelphia, November, 1958,[3] (2) Treatment of Tuberculosis in Children, A Statement by the Committee on Tuberculosis and Respiratory Diseases in Children of the American Thoracic Society, March, 1960.[4]

In these two surveys, the arbitrary age limit of 36 months for INH prophylaxis has been questioned for a variety of reasons. These include such factors as recent conversion, intercurrent infections (especially measles and pertussis), steroid medication, as well as racial and socio-economic factors.

For our own pilot study, we decided to use a completely nondiscriminatory system, including all definitely positive reactors of any age, regardless of whether or not they were known to be recent converters.

It is not the purpose of this paper to enter into theoretical arguments such as whether or not the supposedly safer age group may not be safe enough, or whether even the approximate time of conversion can be ascertained in the majority of cases. Rather, we offer as a striking illustration the case histories of one specific endemic of active tuberculosis in the fifth grade of a parochial school in a Milwaukee suburb.

From the Outpatient Department of Milwaukee Children's Hospital and the Department of Pediatrics, Marquette University, School of Medicine.

Doctor Kassowitz is Clinical Professor of Pediatrics, Emeritus, Marquette University School of Medicine.

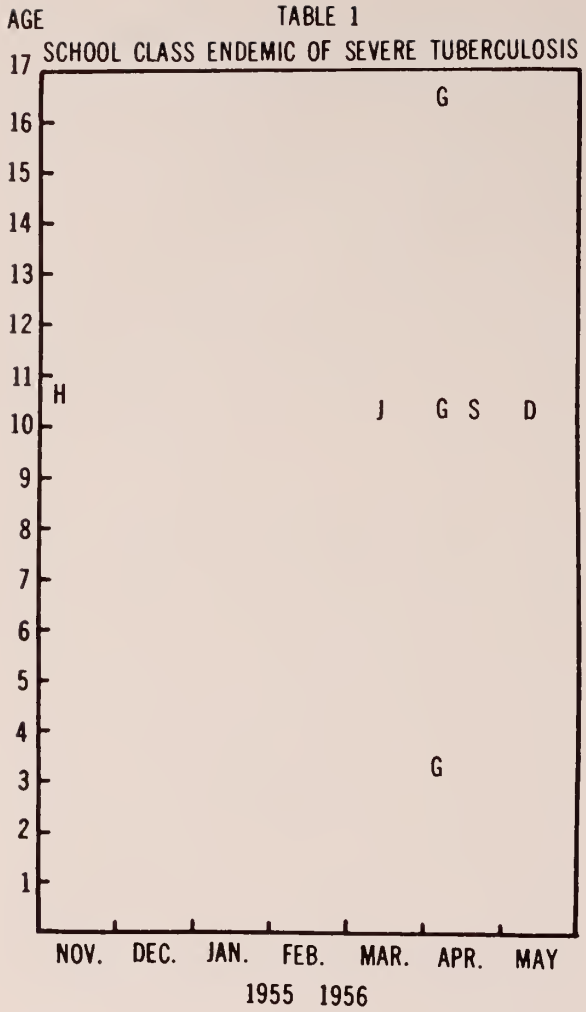


Table 1 indicates the 7 cases of active tuberculosis that were found in this school, but it does not include another 13 cases referred for sanitarium care as a result of this study. The 5 following case summaries will serve to illustrate our problem.

Robert H., born Apr. 28, 1945, admitted Nov. 3, 1955, tuberculous meningitis, brain tuberculoma with amaurosis, no recognizable pulmonary lesion, recovery, no family contact.

Judith J., born July 4, 1945, admitted Mar. 23, 1956, pulmonary tuberculosis, moderately advanced, recovery, no family contact.

Judith G., born Aug. 26, 1945, admitted Apr. 20, 1956, pulmonary tuberculosis, far advanced, recovery, two family contacts.

Richard S., born May 2, 1945, admitted Apr. 24, 1956, tuberculous pleuritis with effusion, recovery, no family contact.

Michael D., born Nov. 15, 1945, admitted May 1, 1956, tuberculous pleuritis with effusion, recovery, no family contact.

In the school that these 10-to-11-year-old children attended, there had been no periodic tuberculin testing program. Had such a program existed, the duration of any infection would have been known, and converters could have been given the benefit of chemoprophylaxis. Under existing circumstances, however, positive reactors without demonstrable lesions or clinical manifestations would be denied chemoprophylaxis under presently accepted standards of practice.

I am sure that all of us who are familiar with the problem of childhood tuberculosis can add any number of similar experiences pertaining to the supposedly less susceptible age group.

Our method of procedure was as follows: all medical outpatients at our hospital, regardless of their main diagnosis, were urged to have tuberculin tests. In order to facilitate matters, a sign in bold letters was posted, "PLAY SAFE, HAVE YOUR CHILD SKIN TESTED FOR T.B."

The test material consisted of old tuberculin diluted 1:1000, and the amount used was between 0.1 and 0.2 cc. The reading was done after two days. Any reaction with an erythematous induration of 5 mm. or more in diameter was recorded as positive. Any reaction of lesser size was followed by retesting with a dilution 1:100.

Of the total outpatient registration, only 22% of the parents gave their consent to the testing, and of these, 25% did not follow through by returning for the reading. This we consider an important experience which indicates the lesser yield of an outpatient case finding project compared to a systematic survey of school children. The psycho-

TABLE 2

	Total Census	No. Tested	Not Returned	Negative Reactors	B.C.G.	Positive Reactors	I.N.H. Treated
Mar. 57–Feb. 58	4,078	1,138 (28%)	248 (22%)	832 (94.5%)	6	48 (5.5%)	42
Mar. 58–Feb. 59	4,241	812 (19%)	190 (24%)	599 (96.3%)	3	23 (3.7%)	23
Mar. 59–Feb. 60	3,645	682 (19%)	214 (31%)	409 (90%)	3	42 (10%)	12
TOTAL 3 Years	11,964	2,632 (22%)	652 (25%)	1,840 (93%)	12	113 (7%)	77

logic and epidemiologic disadvantages of the individual approach, in the absence of a city-wide program, became distressingly obvious.

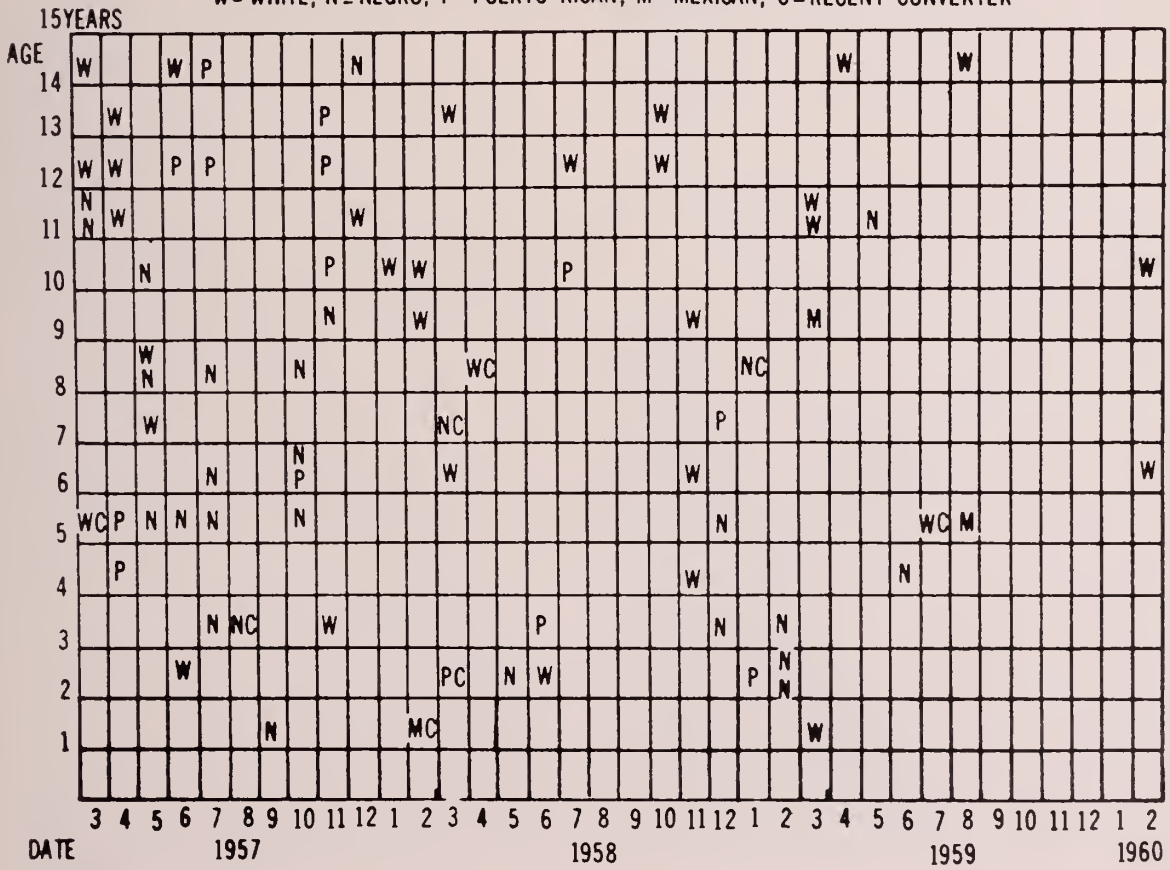
Table 2 gives a numerical breakdown of the total number of patients who submitted to tuberculin testing, the number who fell by the wayside through failure to return for the reading (we can call them the psychologically negative ones), the number of negative reactors (the epidemiologically negative ones), the number of positive reactors, and finally the number who cooperated in the six months' program of ambulatory chemotherapy.

Among the 1,053 children in whom the tests were completed, 113, or 10.7%, positive reactors were found. This is a significantly higher percentage than the 3.5% of positive reactors found in our survey of the years from 1945 to 1955.[5] All reactors were subjected to a review of family and personal history, chest x-ray, physical examination and blood sedimentation rate. In all, 20 demonstrably active or suspected cases were referred for admission to the county sanitarium. The parents of all the children with positive tests, but without demonstrable lesions, received a simplified but truthful statement of the significance of a positive skin reaction without any other evidence of the disease itself. The important possibility of preventing a flare-up of the infection through the use of INH was impressed upon them, the safety of this inexpensive drug was stressed, and the need for regular administration was emphasized.

In this study we chose a uniform dosage of 5 mg. of isoniazid per kilogram of body weight (in liquid or solid form, depending on age) for a period of six months. Although recommendations for larger dosages and for longer periods of administration have been made, our decisions were based on the first report of the U. S. Public Health Service by Ferebee and Palmer,[6,7] which showed that 5 mg. per kg. given for 26 weeks prevented any mortality in guinea pigs inoculated with a virulent strain, and that, after an untreated

TABLE 3. CHILDREN ON ISONIAZID PROPHYLAXSIS ACCORDING TO DATE, AGE, RACE, RECENT CONVERSION

W = WHITE, N = NEGRO, P = PUERTO RICAN, M = MEXICAN, C = RECENT CONVERTER



interval, a new challenge caused only a localized, B.C.G.-like lesion.

Whether this particular method of tuberculosis prevention will prove partially or fully effective will not be definitely known until these children have reached maturity. But in the meantime, an analysis of our pilot study will permit some definite evidence to indicate its short term efficacy.

The total number of reactors treated for six months was 77, 16 under 3 years, 61 from 3 to 14 years of age. The breakdown according to race: 33 whites, 27 negroes, 14 Puerto Ricans, 3 Mexicans. Only in 8 cases were negative reactions previously recorded, while the other 69 had an initially positive test.

Following cessation of treatment, the children were called in for re-evaluation every three months. Forty-two cases have been observed from 18 to 30 months after INH was discontinued; 35 of them were found completely negative with stabile or absent x-ray lesions and normal sedimentation rates. However, 7 children had left town, or could not be located for their last re-evaluation.

In comparing the number of active tuberculosis cases referred for hospitalization, 23 were found between March, 1954, and February, 1957, and 20 between March, 1957, and February, 1960. None of these had been given previous chemoprophylaxis.

Twenty cases who had been under INH medication for 24 to 30 months were retested with Old Tuberculin 1:1000. Of these, 12 showed a reduction in size and intensity of reaction, but 2 were found to be completely negative to this strength as well as to the 1 mg. (1:100). This observation seems to indicate that isoniazid given in this amount and for this period of time may even be able to destroy the bacterial antigen in some cases completely or almost completely.

While the tuberculin test is held to be mandatory for any case-finding program in childhood, it should also be considered as the first step in the prevention of clinical tuberculosis. Until testing is established as a routine procedure in health centers and the schools of a community, it will be necessary for us to expend the time, effort, and patience necessary to convince parents of its value as a precautionary measure.

Any definitely positive reactor throughout childhood ought to be given the benefit of doubt. If he has an apparently inactive primary lesion, we must question the possibility and probability of it remaining dormant or healed under all possible circumstances. If we limit chemoprophylaxis to an arbitrarily defined most susceptible age group, to those in whom a chance discovery indicates a recent positive conversion, to those with intercurrent viral or bacterial infections, to children receiving steroid therapy, or to the groups facing peculiar racial or socio-economic hazards, if we thus limit ourselves, we are merely sampling our problem. By so doing we may be running the risk of missing the best, or even the last, opportunity of prevention of active tuberculosis.

The ambulatory administration of isoniazid to clinically inactive and asymptomatic positive reactors is usually well accepted by parents and well tolerated by children.

Following is a summary of our 36 months of experience with this project:

Summary

A program of treating 77 positive tuberculin reactors (children of all ages) for six months was carried out. The reasons against eliminating certain age groups from chemoprophylaxis are given, supported by a specific experience with a severe tuberculosis endemic in a fifth grade school class. No instance of reactivation during or following the administration over a 36-months' period of observation has been noted. In 12 cases a reduction of tuberculin allergy was demonstrated, and in 2 cases a complete reconversion to a negative reaction (1 mg. O. T.) was obtained. The final answer as to a long range protection against reactivation of tuberculosis during puberty and adolescence will be forthcoming after further observation.

1700 West Wisconsin Avenue (3).

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Liver Scanning

By JOHN R. CAMERON, Ph. D., and FRANK F. GOLLIN, M. D.

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THERE IS a need for graphically demonstrating organs not visualized radiologically by using contrast media technic. With the advent of radioisotopes it is now possible to demonstrate the outline and defects in the liver and thyroid as well as pathologic processes in other organs such as the brain and the circulatory system.

This report is concerned primarily with a technic of visualizing the functioning liver tissue and thus demonstrating defects due to tumors. The technic, which is called liver scanning, involves injection intravenously of a small quantity of a radioactive isotope and the subsequent detection and localization of this isotope in the liver using the equipment as outlined in the next section. The report covers the results of 135 scans carried out on 83 different patients.

Equipment

The instrumentation for doing the liver scans is shown in Figure 1. A 3″ diameter x 1½″ thick scintillation crystal detects the gamma rays from the radioactive material as it moves back and forth over the patient. This detector is shielded with about 100 lb. of lead (A) to avoid detecting radiation from other parts of the body. The lead shielding has 61 tapered holes pointing at a spot 3 inches below the heavy shield. The size of these holes is such that the detector "sees" a cone of tissue about 1 cm. in diameter at the three-inch focal distance and 3 or 4 cm. in diameter at a distance of six inches from the lead shield. This puts a limitation on the smallest observable defect. The individual gamma rays detected by the crystal produce electrical pulses which are counted by the scaler (B). The scaler can be adjusted to count only pulses from unscattered gamma rays and is set to flash a light for each group of 4, 8 or 16 gamma ray pulses. This light is mechanically connected to the detector and moves over a film under hood (C). It darkens the photographic film in areas corresponding to the greatest radioactivity in the body. This recording system has the advantage that it diminishes background and emphasizes the areas of greatest activity. This permits better visualization of any variations of radioactivity in the liver.

Technic

Two suitable radioisotopes exist which can be used in liver scanning: radioactive iodine (I^{131}) and radioactive gold (Au^{198}). I^{131} is used as a label with rose bengal (tetraiodotetrachlorofluorescein) which is taken up by the hexagonal cells of the liver. Colloidal radioactive gold is specifically taken up by the Kupffer cells.

Fig. 1—Equipment used for liver scanning.

From the Department of Radiology, University Hospitals, Madison.

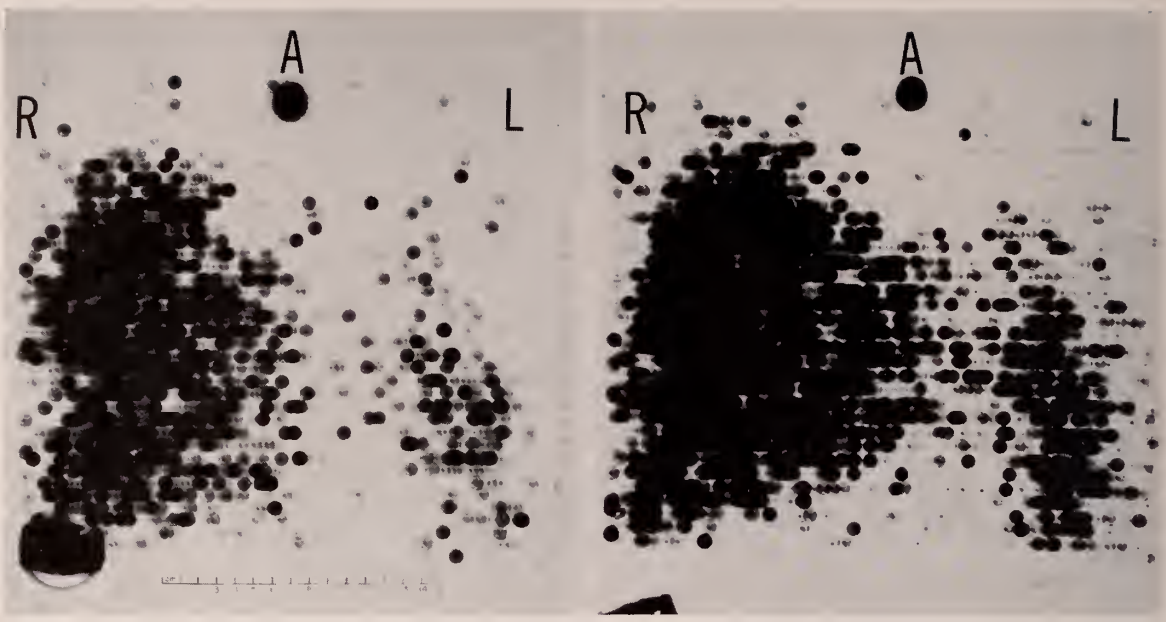

Fig. 2—Woman, 76 years old, with a tissue diagnosis of lymphosarcoma, stomach and liver. Note active uptake in spleen. There was a five-hour lapse between scans. Point A is 7 cm. above the xiphoid tip.

Early work was carried out with rose bengal labeled with I^{131}. This is now seldom used because it does not remain in the liver for a long period of time. To be accurate, scanning must be carried out within an hour. If a scan has to be repeated, a second injection is necessary. There is increased background interference with rose bengal I^{131} as the gallbladder and intestines also take up this isotope and will register on the scan. However, it has the advantage of giving a considerably smaller amount of radiation to the patient than radioactive gold. For this reason it is still the preferred diagnostic procedure in young patients when a liver scan is necessary.

A single dose of colloidal radioactive gold can be utilized in scanning from 10 minutes up to 48 hours after injection. This enables one to take repeat scans without further administration of the isotope. The disadvantage of Au^{198} is that the patient is exposed to a higher radiation exposure, but there is no evidence to indicate that the dose employed is injurious. The total radiation dosage would be comparable to that received during fluoroscopy during a gastrointestinal study.

No preliminary sedation is employed. The patient is brought to the isotope laboratory and given approximately 200 microcuries of colloidal Au^{198} intravenously. No reactions to the drug have been observed, nor have any patients been unable to tolerate the procedure.

Following a ten-minute lapse the patient is placed in a supine position on an adjustable cart and raised as close as possible to the detection mechanism. The detector is activated and moved about over the liver and locked over the most active area. A one-minute count of the amount of radiation entering the detector is taken over this area and the scaler is adjusted to give about 150 light flashes per minute at this location.

A skin mark is placed 8 to 10 cm. above the tip of the xiphoid process for purposes of orientation. Limits are set for the lateral, superior and inferior borders of the scan by moving the scanning collimator over the liver area and fixing the stop switches which limit the area to be scanned. The film is placed in position and an identification number is imprinted on the right side of the film.

The positioning light of the detector is placed over the skin mark and its position is marked on the film. The detector is next placed at one corner of the area to begin the actual scan. It moves automatically back and forth over the patient within the set limits and shuts itself off at the end of the scan. The time required to complete the scan is 30 to 45 minutes depending on the size of the liver.

Clinical Application

A liver scan accurately portrays the size and shape in a single plane of the scanned

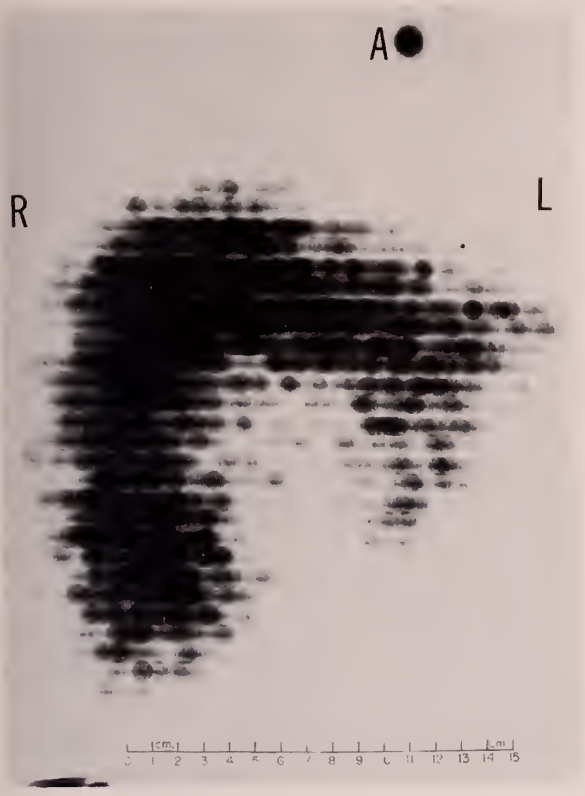

Fig. 3—Woman, 49 years old, who had a radical mastectomy for an adenocarcinoma of the breast 3 years previously. Note large defect in lower mid liver. Point A is 10 cm. above the xiphoid tip.

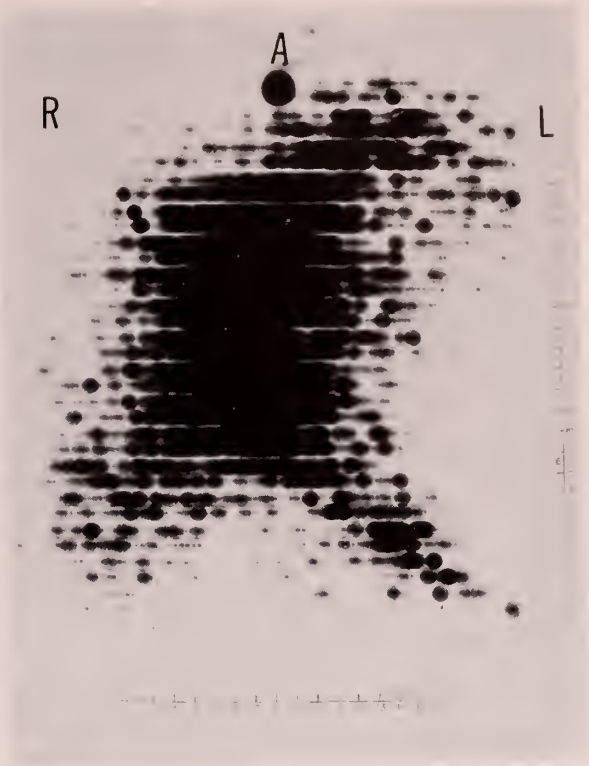

Fig. 4—Woman, 70 years old, with an adenocarcinoma of the rectum. Liver metastasis confirmed at surgery. Bizarre shope due to hypertrophy plus metastatic lesions. Point A is 10 cm. above the xiphoid tip.

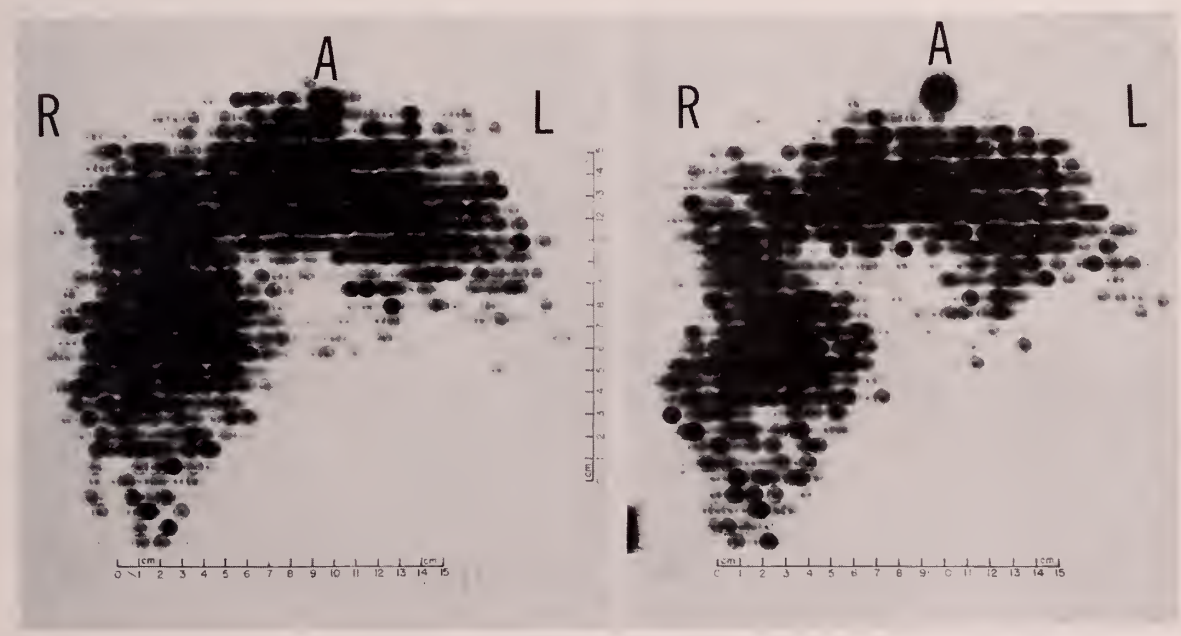

Fig. 5—Woman, 41 years old, with a rectosigmoid adenocarcinoma. Metastatic liver lesions noted at surgery. Liver rescanned in 4 hours. Point A is 12 cm. above the xiphoid tip.

liver. In those patients where the liver edge could be palpated the agreement with the liver edge as shown on the scan was very good. For purposes of discussion, pathology as suggested only by liver size will be ignored. The patients included in this report were referred for liver scans because of possible liver involvement by tumor. Diagnoses were made on the basis of the presence or absence of defects in the uptake of radioactive gold by the liver. A breakdown of patients according to primary diagnosis is given in Table 1.

TABLE 1—*Classification of Cases as to Primary Diagnosis*

Carcinoma of colon	15
Carcinoma of rectum	12
Carcinoma of breast	9
Bronchogenic carcinoma	5
Carcinoma of cervix	5
Carcinoma of pancreas	5
Primary hepatoma	4
Carcinoma of uterus	4
Liver abscess	4
Carcinoma of ovary	3
Miscellaneous	15
Undiagnosed	2

Eighty-three patients were examined by liver scanning; a positive diagnosis of liver defects, presumed to be due to involvement by tumor, was made in 41 cases. The diagnosis was confirmed in 22 of these 41 cases at surgery, autopsy, or by biopsy. Seven cases diagnosed as negative were found to have metastatic lesions at surgery, autopsy, or by biopsy. In one case where a positive diagnosis was made, no liver involvement was noted on gross inspection at surgery.

It is of interest to note that defects were noted in the right lobe 22 times and the left lobe 19 times, even though the right lobe accounts for three-fourths to four-fifths of the liver mass. This agrees with other observations[1,2] that defects are detected more readily in the thinner tissue.

Lateral liver scans have been attempted but they are generally of inferior quality due to the greater thickness of the liver in this view.

The spleen usually does not filter out the radioactive gold. In some cases, however, as reported by Doehmer et al.,[1] where the liver was hypertrophic there appeared to be a compensatory reaction and the spleen took up the radioactive gold as noted in Figure 2. Splenic uptake of radioactive gold was noted in several cases included in this report.

Numerous scanning experiments were carried out using various concentrations of radioactive gold and simulated "cold spots" in a phantom. Defects of less than 2 cm. in diameter could not be detected. Defects of larger size were missed if the focal spot of the detection apparatus fell above or below the defect. Surrounding active tissue obscured the defect.

Artificial defects or artifacts did appear occasionally in scans, and it is important to rescan patients where questionable abnormalities exist.

Summary

The apparatus used and the procedure for producing liver scans using radioactive isotopes have been described.

The procedure is a valuable adjunct in directly demonstrating liver size and the extent and distribution of liver metastases. It may be of importance in determining the advisability of surgical procedures in some cases.

In the series of 83 cases included in this report a definite diagnosis was established by surgery, biopsy, or autopsy in 30 of these cases. Of these 30 cases a correct diagnosis was made by liver scanning in 22, or 73% of the cases.

The procedure is relatively new and its accuracy should improve as new equipment becomes available and with the advent of new radioactive pharmaceuticals. Some of these may have an affinity for the tumor itself and thus permit better localization of tumors in the right lobe.

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Bendroflumethiazide in Cardiac Edema

By S. E. SIVERTSON, M.D.

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ABNORMAL RETENTION of salt and water with accumulation of extracellular fluid is characteristic of circulatory insufficiency.[1] This excess fluid not only causes discomfort to the patient but also places a physiologic burden on an impaired heart which, unless promptly relieved, may lead to further cardiac damage. It is obvious that any treatment should be directed towards the resolution of edema in cardiac patients as quickly and effectively as may be possible with safety to the patient. Within the past few years, notable advances have been made in the development of potent diuretic drugs which are rapid-acting, effective when given by mouth, relatively nontoxic, and to which refractoriness does not develop. With the help of these newly discovered diuretic drugs, it has now become possible to obtain and maintain an edema-free state in cardiac patients in a convenient, safe, and more or less routine manner.

The present report describes the findings recorded in private patients with heart disease complicated by congestive failure following the addition of bendroflumethiazide (Naturetin) to the therapeutic regimen. Bendroflumethiazide is one of the most potent of the benzothiadiazine diuretic compounds yet developed.[2] In clinical studies, doses of 5 mg. of bendroflumethiazide induced a marked increase in the urinary excretion of water, sodium, and chloride—greater than that resulting from the administration of 1 gm. of chlorothiazide and equal to that produced by 50 mg. of hydrochlorothiazide. On the other hand, bendroflumethiazide had less effect than either chlorothiazide or hydrochlorothiazide, in the dosages given, on potassium and bicarbonate loss.[3]

Methods and Materials

The Patients

Altogether 24 patients were treated with bendroflumethiazide to control cardiac edema. Of these, 9 were women and 15 were men. The range in their ages was 47 to 84 years, 19 of the 24 patients being at least 60 years old. All presented symptoms and physical findings of heart disease with edema. Most of the patients in this predominantly elderly group had advanced heart disease; 10 exhibited uncontrolled cardiac arrhythmias; and 2 had a history of myocardial infarction. In addition to edema found in every patient, other complications were present in most of the patients such as angina pectoris, hypertension, generalized arteriosclerosis, nephrosclerosis, pyelonephritis, obesity, diabetes mellitus, prostatism, nodular goiter, duodenal ulcer, glaucoma, and chronic sinusitis. Coronary artery disease with congestive failure was the principal diagnosis in every case except two, in which heart disease was found secondary to pulmonary disease, associated with heart failure.

The Medication

During the initial phase of this trial, bendroflumethiazide, without potassium supplement, was prescribed as tablets containing 2.5 mg. or 5 mg. of the drug for total daily dosages of 5 mg. or 10 mg. When bendroflumethiazide with potassium supplement became available later in the study, this preparation (Naturetin c̄ K) was employed, each tablet containing 5 mg of bendroflumethiazide and 500 mg. of potassium chloride. The dosage of bendroflumethiazide with potassium chloride prescribed in every case was 1 or 2 tablets a day for total daily dosages of 5 mg. or 10 mg. of bendroflumethiazide and 500 mg. or 1,000 mg. of potassium chloride. In addition, each of the patients received concomitant therapy, as indicated, with one or more drugs such as digitalis (digoxin or Gitaligin), nitroglycerin, insulin, antidepressants, antacids, antibiotics, urinary antiseptics, and vitamins. At the time of this report, treatment with bendroflumethiazide and bendroflumethiazide with potassium chloride had been continued in the individual cases for periods varying from 2 weeks to 16 weeks with most patients having been treated for at least 4 weeks.

Bendroflumethiazide was formerly known as benzydroflumethiazide.

TABLE 1—*Results with Bendroflumethiazide in Patients with Cardiac Conditions*

Patient	Age and Sex	Diagnosis*	Administration of Bendroflumethiazide		Other Medications and Therapeutic Measures	Results
			Dosage (mg./day)	Duration (weeks)		
C.S.	57M	CAHDc̄CHF	10	8	Low-salt diet Digoxin Nitroglycerin	Satisfactory. Edema resolved, compensation restored.
E.S.	77F	HCAHDc̄CHF Auricular fibrillation	5	5.5	Digoxin	Satisfactory. Edema resolved, compensation restored and blood pressure reduced to satisfactory levels.
R.C.	72F	HCAHDc̄CHF Angina pectoris Obesity	5	10	Syrosyngopine Digoxin	Satisfactory. Patient lost 12 lb. after copious diuresis and showed marked improvement in previous symptoms of angina and dyspnea.
K.H.	77F	CAHDc̄CHF Auricular fibrillation	5	13	Digoxin Low-salt diet Vitamin supplements	Satisfactory. Edema disappeared. Cardiac compensation restored. Patient was later given bendroflumethiazide with potassium chloride with satisfactory results.
A.E.	76M	CHF	10	8	Digoxin Potassium chloride Vitamins	Satisfactory. Cardiac compensation with sense of well-being maintained. Weight remained constant.
K.B.	78M	HCAHDc̄CHF	5	16	Digitalis Antidepressant Antacids	Satisfactory. Cardiac compensation maintained. Response of patient equal to that previously seen with chlorothiazide.
K.K.	53M	Bronchiectasis and emphysema with cor pulmonale Secondary Polycythemia	5	13	Digoxin Antibiotics (periodically) Phlebotomy	Satisfactory. Compensation maintained during 3 months treatment when patient was hospitalized because of a marked exacerbation of bronchiectasis complicated by bronchopneumonia and heart failure. Serum electrolytes were found to be as follows: chloride 78 mEq./l.; potassium 3.4 mEq./l.; and sodium 142 mEq./l. Patient recovered; subsequently he was placed on bendroflumethiazide with potassium chloride and did very well.
H.G.	63M	CHF	10	3.5	Digoxin	Unsatisfactory. Though the patient showed satisfactory diuretic response to bendroflumethiazide, he complained of feeling "groggy" after 3.5 weeks of therapy and the drug was withdrawn.
A.D.	47M	HCAHD Duodenal ulcer Posterior inferior cerebellar artery insufficiency	5	Sporadic	Syrosingopine	Unsatisfactory. The blood pressure was not reduced effectively. The patient developed nystagmus and vertigo on two separate occasions after receiving bendroflumethiazide and he refused to continue treatment. Patient subsequently died from cerebral thrombosis, which probably caused the symptoms.
O.E.	64F	CAHDc̄CHF Diabetes mellitus Pyelonephritis, chronic Duodenal ulcer with hemorrhage Hepatic cirrhosis	5	4	Digoxin Insulin Urinary antiseptics	Unsatisfactory. The heart failure, diabetes, and renal problem were controlled nicely but the hemorrhage from the duodenal ulcer resulted in death.

* CHF represents congestive heart failure. HCAHD represents hypertensive coronary arteriosclerotic heart disease. CAHD represents coronary arteriosclerotic heart disease.

Results

The findings recorded in 10 of the 24 patients in this series after treatment with bendroflumethiazide are shown in Table 1; those in the other 14 patients who were treated with bendroflumethiazide with potassium chloride appear in Table 2. The responses to therapy were considered to be satisfactory in all but 3 of the patients treated with bendroflumethiazide and in every one of those placed on bendroflumethiazide with potassium chloride. In these 21 patients who responded satisfactorily, edema was dispersed, all symptoms and objective findings of heart failure disappeared, and cardiac compensation was maintained as treatment was continued. Moreover, a sense of well-being generally accompanied the mobilization of excess fluid with improvement in circulation, the blood pressure was reduced to more satisfactory levels in those patients who had hypertensive heart disease, and patients with arrhythmia showed a tendency to return to normal sinus rhythm or to a controlled heart rate.

The findings in 3 of the 24 patients were not as favorable after treatment, however, as were those in the rest of the series. One patient experienced copious diuresis with relief of edema; but after three weeks of

TABLE 2—*Results with Bendroflumethiazide with Potassium Chloride in Patients with Cardiac Conditions*

Patient	Age and Sex	Diagnosis*	Administration of Bendroflumethiazide with Potassium Chloride		Other Medications and Therapeutic Measures	Results
			Dosage (mg./day)	Duration (weeks)		
A.G.	75M	HCAHD̄ĉCHF Acute pulmonary edema Nephrosclerosis ? Carcinoma of the prostate	5	2	Low-salt diet Digitoxin Antidepressant	Satisfactory. CHF controlled and the patient was ambulatory and getting along well in an old folks' home.
O.Q.	69M	HCAHD̄ĉCHF Uncontrolled auricular fibrillation	10	8	Digoxin Syrosingopine	Satisfactory. Heart has remained compensated.
A.M.	58F	HCAHD̄ĉCHF Paroxysmal tachycardia	5	4	Digoxin Syrosingopine	Satisfactory. Symptoms and objective findings of congestive failure disappeared.
L.H.	68M	HCAHD̄ĉCHF Auricular fibrillation Diabetes Prostatism	5	6	Digoxin Tolbutamide (Orinase)	Satisfactory. Heart has remained compensated.
R.M.	82F	HCAHD̄ĉCHF Bronchiectasis	5	6	Digoxin Paregoric	Satisfactory. Heart has remained compensated.
J.H.	47F	HCAHD̄ĉCHF Myocardial infarction Obesity	5	5	Syrosingopine Reduction diet Vitamin supplements Phenobarbital Nitroglycerin	Satisfactory. Profound weakness and tiredness experienced with bendroflumethiazide without potassium supplement no longer troublesome.
R.C.	72F	HCAHD̄ĉCHF Obesity	5	4	Syrosingopine Digoxin	Satisfactory. Patient doing very well with no evidence of side-reactions or toxicity.
F.W.	64M	CAHD̄ĉCHF	5	5	Digoxin Low-calorie diet	Satisfactory. Excellent results. Congestive failure controlled and patient has had abdominal incisional hernia repaired.
H.E.	64M	CAHD̄ĉCHF Chronic nasorhinitis Chronic sinusitis	5 to 10	6	Digoxin Nose spray	Satisfactory. With control of CHF, the chronic sinus and nasal congestion disappeared. Patient gained 5 lb. thought to be due to edema, so the dosage of bendroflumethiazide was increased to 2 tablets daily.
F.K.	63F	CAHD̄ĉCHF Auricular fibrillation Nodular goiter Pneumonia Pulmonary infarct Pulmonary emboli	10	7	Digoxin Antibiotics	Satisfactory. Heart has remained compensated. Fibrillation has continued, but at a controlled rate. With clearing of the pneumonia, the patient showed marked clinical improvement with an improved sense of well-being.
H.R.	71M	CAHD̄ĉCHF	10	7	Digoxin Mercurial diuretic periodically	Satisfactory. Cardiac compensation maintained.
W.M.	74M	CAHD̄ĉCHF Auricular flutter Acute bronchitis Acute laryngitis Acute balanitis Pulmonary emphysema	10	3	Digitalis Antibiotics	Satisfactory. Patient doing very well. He had received prior therapy with bendroflumethiazide and digitalis and did well until medications were exhausted; he did not replenish them and auricular flutter recurred.
E.S.	63M	CAHD̄ĉCHF Myocardial infarction	5	8	Gitalin Anticoagulant Nitroglycerin	Satisfactory. Heart remained compensated.
E.G.	63M	Acute pulmonary edema Polycythemia vera Pickwickian syndrome? Chronic alcoholism Gout	10	8	Digoxin Weight-reducing diet Phlebotomies	Satisfactory. Patient's condition is excellent.

* CHF represents congestive heart failure. HCAHD represents hypertensive coronary arteriosclerotic heart disease. CAHD represents coronary arteriosclerotic heart disease.

treatment with bendroflumethiazide, he complained of feeling "groggy" and the drug was withdrawn. Another patient, who had hypertension and dizziness associated with heart failure, failed to show an effective reduction in blood pressure levels. On two occasions after receiving bendroflumethiazide this patient developed nystagmus and vertigo and refused to continue therapy. However, the patient subsequently died from posterior inferior cerebellar artery thrombosis. His condition prior to this stroke was probably due to intermittent insufficiency of this artery. In a third patient, heart failure, diabetes, and pyelonephritis were well controlled under a therapeutic regimen which included digoxin, insulin, and urinary antiseptics as well as bendroflumethiazide; but hemorrhage from the associated duodenal ulcer present in this patient resulted in her death.

This death obviously is attributable to one of the presenting conditions rather than to the therapeutic agent.

Unwanted effects, other than "grogginess" and vertigo described above, which may be attributable to the administration of bendroflumethiazide, were observed in two other patients in this series. Relatively low levels of serum chloride (78 mEq./l.), serum potassium (3.4 mEq./l.), and serum sodium (142 mEq./l.) were found in one patient (K.K.) hospitalized after three months' treatment with bendroflumethiazide because of marked exacerbation of bronchiectasis complicated by bronchopneumonia and right heart failure. No control levels had been determined in this case, however, so that no comparative evaluation could be made of serum electrolytes before and after treatment with bendroflumethiazide. Following his recovery from the acute phase of his illness, this patient was placed on bendroflumethiazide with potassium chloride, and at the time of this report he had continued on the medication for two months without apparently any difficulty. Another patient (J.H.), who was treated with bendroflumethiazide for two months until profound weakness and tiredness developed, was transferred to bendroflumethiazide with potassium chloride and thereafter had no further trouble from these effects. No other evidence of unwanted effects or toxicity were seen in any of the patients in this series who were treated with bendroflumethiazide or bendroflumethiazide with potassium chloride.

Comment

The findings of this study confirm previous reports that bendroflumethiazide is an effective diuretic agent in dosages as low as 5 mg. a day.[4-6] The satisfactory responses to treatment, with dispersal of edema accompanied by restoration of cardiac compensation in almost all of the patients in this series, point to the high effectiveness of the drug in controlling cardiac edema. Although lowering of the blood pressure in one patient reported here was unsatisfactory, a number of factors were present in the case which may have influenced the results. However, it should be noted that rather equivocal results have followed the use here of bendroflumethiazide in the treatment of several other patients with hypertension, uncomplicated by cardiac edema, who are not included in this report. While some have exhibited a satisfactory lowering of the blood pressure following administration of the drug, others have not. In those patients who have not responded, however, as in the patient mentioned above, other factors such as advanced age and severe complicating conditions may have influenced the results.

Summary

Bendroflumethiazide, with or without potassium supplement, has been used in the treatment of 24 patients to control cardiac edema. The drug without potassium supplement (Naturetin) was administered to 10 patients in daily dosages of 1 or 2 tablets, each tablet providing 2.5 mg. or 5 mg. of the drug. The other 14 patients in this series were placed on the drug with potassium supplement, (Naturetin $\overline{c}$ K), also in daily dosages of 1 or 2 tablets, each tablet providing 5 mg. of bendroflumethiazide and 500 mg. of potassium chloride. Treatment was continued in the individual patients for periods ranging from 2 weeks to 16 weeks.

The therapeutic results were satisfactory in 21 of the 24 patients with resolution of edema and disappearance of all signs and symptoms of heart failure. In these patients cardiac compensation was maintained as treatment was continued. Patients generally experienced a sense of well-being as circulation improved; and those who had presented uncontrolled auricular or ventricular arrhythmias showed a return to normal sinus rhythm or a controlled heart rate.

Unwanted effects of grogginess, weakness, and low levels of serum electrolytes were observed in 3 patients; these may have been related to the treatment with bendroflumethiazide. The medication was withdrawn from the patient who complained of feeling "groggy," and the other 2 patients were subsequently treated with bendroflumethiazide with potassium chloride without further difficulty from the effects observed during prior therapy. Another patient developed nystagmus and vertigo while on bendroflumethiazide; but there is considerable doubt whether these effects were related to treatment, since the patient died from cerebral vascular thrombosis shortly after discontinuance of the medication. Both of these effects could have been related to that approaching development.

The satisfactory therapeutic results observed, with restoration and maintenance of

cardiac compensation in almost all of the patients in this series, point to the high effectiveness of bendroflumethiazide in controlling cardiac edema. The provision of the potassium supplement in bendroflumethiazide with potassium chloride appears to offer some advantage in reducing the effects of urinary electrolyte loss inherent in the continued administration of any effective diuretic agent.

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State Medical Society of Wisconsin

CLINICOPATHOLOGIC CONFERENCE

Guest Editor: GORTON RITCHIE, M. D.
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CASE PRESENTATION*

The patient, a single white woman, was admitted to the hospital on Apr. 17, 1934, at the age of 46 years. Her chief complaints were pallor, easy fatigability, and dyspnea on effort.

A diagnosis of aleukemic leukemia was made, and she was treated with blood transfusions. She developed a severe reaction to the blood given, but apparently recovered from this episode without any lasting ill effect. After three weeks in the hospital, she was discharged in an improved condition.

During the next 13 years, until 1947, she had recurrent attacks of jaundice, not accompanied by abdominal pain. Her stools throughout this period were normal in color. She had recurrent pyelonephritis, and in 1941 she underwent an appendectomy for acute gangrenous appendicitis. She received a total of 35 blood transfusions during this time, with frequent severe reactions. At another hospital a diagnosis of hemolytic anemia was made, and a splenectomy was performed there in 1941.

In June, 1947, she first noticed that her urine was dark-colored. This did not occur at any particular time of day but recurred several times over a period of several months. She lost 10 pounds in the three or four months before her last admission to the hospital in November, 1947. During this period (1934 to 1947) most of her time outside the hospital was spent in an institution for mental diseases.

*From Columbia Hospital.

Her last admission to the hospital was on Nov. 26, 1947, at which time she had paroxysmal auricular tachycardia that was easily controlled.

During her stay at the hospital, her course was similar to that described before, except that it was found that the transfusion of triple-washed erythrocytes, repeated four times, was not followed by hemolytic reactions. She received considerable medication for her mental aberrations and for other symptoms which were felt to have no relation to her hematologic manifestations. At one time her abdomen became distended, and a diagnosis of mesenteric thrombosis was considered. Conservative treatment was instituted, and her abdominal symptoms were relieved in a few days.

Because of her mental condition she became unmanageable, and on Jan. 2, 1948, she was transferred to the county hospital, where she remained until her death on Sept. 2, 1948.

Physical examination and laboratory findings during her last hospitalization were within normal limits except for the following:

Blood: Hemoglobin, 6.5 gm. per 100 ml.; nucleated erythrocytes, 2%; polychromasia, present; reticulocytes, 8.6%; icterus index, 14; cold hemolysins, absent; heat resistance test of erythrocytes, strongly positive; acid hemolysis test, strongly positive; test for hemosiderin in serum, strongly positive.

Bone marrow: Normoblastic hyperplasia.

Discussion

Doctor Mukhtar Gani: Before I start the discussion of this case I would like to ask a few questions. First, it was mentioned in the protocol that in 1934 the patient was diagnosed as having aleukemic leukemia. Yet this patient was living 13 years later without any specific treatment for leukemia. This seems very unlikely. Was this a diagnosis or merely a clinical impression?

Doctor Dionisio Pinero: This was a clinical impression because there was no bone marrow examination performed at that time.

Doctor Gani: Was there anything in the patient's record to suggest a familial type of jaundice?

Doctor Pinero: There was nothing of that sort in the patient's family history.

Doctor Gani: Was a Coombs test done on this patient?

Doctor Pinero: During the earlier hospitalization there was no Coombs test, but later this test was negative.

Doctor Gani: Was a fecal urobilinogen determination done on this patient?

Doctor Pinero: I can find no evidence of this in the patient's record.

Doctor Gani: This patient was a 47-year-old woman when her symptoms began. There are several prominent features in her history. Over a peroid of 13 years she had periodic episodes of anemia with associated symptoms. The anemia was of such a grade that it required the administration of 35 units of blood during the 13-year period. Another important feature is that she had been having periodic attacks of jaundice throughout the 13 years. She apparently recovered from these spontaneously. A third feature is that she had been passing dark urine over a period of four to five months before her admission in 1947.

At this point the causes of dark urine should be mentioned. Drugs such as phenylazo-diamino-pyridine hydrochloride (Pyridium) cause dark urine, but there was no evidence that this patient had taken any such drugs. Hematuria can obviously cause dark urine, but the urinalysis of this patient revealed no erythrocytes. Porphyrinuria can also cause dark urine, but there was no evidence of porphyrinuria in this patient. Myoglobinuria can cause dark urine; and this may be caused by crushing injuries to the extremities, it may be caused by thrombosis of an artery supplying a large muscle mass, e.g. the femoral artery, or it may be caused by thermal electric shock. None of these conditions was present in this patient, so we may safely say that the dark urine was not caused by myoglobinuria. The only other possible condition which might be considered is hemoglobinuria. This was apparently the cause of the passing of dark urine. This was a patient with periodic attacks of anemia extending over a period of 13 years, periodic attacks of jaundice extending over the same period, and hemoglobinuria for four to five months before admission. Considering these features, we are obviously dealing with a case of hemolysis. That impression is further strengthened by the fact that the patient's reticulocyte count was 8.6% and she had polychromatophilia and nucleated erythrocytes in her peripheral blood. Her bone marrow showed normoblastic hyperplasia which is associated with a hemolytic process. Her icterus index of 14 was slightly raised, but her serum bilirubin was only 0.5 mg. per 100 ml. We must explain this normal serum bilirubin on the fact that the amount of serum bilirubin in hemolytic processes depends upon two things; namely, the extent of the hemolysis, and the ability of the liver to excrete the bilirubin into the bile. It is possible to have a large degree of hemolysis; but with a liver which is able to excrete it rapidly into the bile, the serum bilirubin does not rise very high. Of great importance in this patient would be the fecal urobilinogen and the urinary urobilinogen. In hemolytic diseases the urobilinogen in the feces is often greatly increased, but apparently neither the fecal urobilinogen nor the urinary urobilinogen was determined in this patient. The fecal urobilinogen must have been considerably increased in this patient, if there was chiefly a hemolytic process. Therefore we must conclude that essentially this patient had been having a hemolytic process.

Hemolytic disorders may be divided into various categories; one broad classification is by etiology, or mechanism, such as extracorpuscular and intracorpuscular causes. A more convenient classification, however, is according to the tempo; that is, a division into acute and chronic processes.

Most prominent among the acute hemolytic diseases are those occurring in situations characterized by immune bodies in the serum. Transfusion with incompatible blood comes

first to mind, and this may be occasioned by the activity of anti-A, anti-B, or anti-Rh antibodies. Hemolytic disease of the newborn (erythroblastosis fetalis) is also in this class. Infection may bring about hemolysis, and in this category we may include the cold agglutinins or hemolysins found most frequently in patients with atypical pneumonia, and hemolysins elaborated by streptococci; the damage to erythrocytes by intracorpuscular organisms, such as malaria parasites and Bartonella organisms, also causes hemolysis and this may occur in infectious mononucleosis. Malaria often goes into a chronic phase. Hemolysis caused by drugs or chemicals may be divided into cases in which the effect is definitely related to the size of the dose, and those in which hypersensitivity of the patient is the deciding factor. Among those chemicals in which the size of the dose is important are phenylhydrazine, naphthalene, trinitrotoluene, benzine, phenacetin, and arsine. On the other hand the sulfonamides, quinine, para-aminosalicylic acid, neoarsphenamine, methoin (Mesantoin), and many others in extremely minute doses may cause hemolysis, apparently depending on previous hypersensitization of the patient to the drug.

Physical agents, such as heat, may cause hemolysis, and the hemolyzing activity of certain snake venoms is well known. These then are a few of the most important causes of acute hemolytic disorders.

The etiology of chronic hemolysis may profitably be divided into extracorpuscular and intracorpuscular causes. Among the former, one class is a sort of grab-bag, comprising leukemia, lymphosarcoma, certain collagen diseases, carcinomatosis, some cases of sarcoidosis and a few other miscellaneous diseases. A second, and for our consideration, much more important category includes idiopathic autoimmune hemolytic anemia. The onset of this disease may be acute or insidious; jaundice recurs along with other evidences of hemolysis, and a positive Coombs test is present, giving evidence that the patient is carrying antibodies in his serum which affect his own erythrocytes. The disease is more frequent in females than in males.

Among the chronic hemolytic conditions with intracorpuscular causes, the first great class is made up of the hereditary defects in the erythrocytes, such as hemolytic spherocytosis (or congenital hemolytic icterus), hereditary elliptocytosis, hereditary nonspecific jaundice, leptocytosis (thalassemia or Mediterranean anemia), and the various diseases related to the presence of abnormal hemoglobins, especially sickle-cell anemia.

The other important disease entity which now appears to be intracorpuscular in type is paroxysmal nocturnal hemoglobinuria, or the syndrome of Marchiafava and Micheli. This disease is characterized by a chronic course, recurring jaundice, anemia, the passage of dark urine, and a violent reaction to the transfusion of blood which is compatible by all our laboratory tests.

In describing our patient, we have a white woman with exacerbations and remissions, and a chronic course lasting over a period of 13 years. This case therefore is clinically compatible with a diagnosis of idopathic autoimmune hemolytic anemia. But one essential feature that we do not have is a positive Coombs test. The Coombs test was negative therefore she does not belong in this group. Considering the secondary anemias, she apparently does not have any of the diseases which cause secondary hemolytic anemia, although it was mentioned previously that she had aleukemic leukemia. It appears however to have been a clinical impression and not a true diagnosis. Apparently all of these causes of secondary hemolytic anemia can be ruled out. She does not appear to have had a chronic infectious disease, such as malaria, which would give her hemolytic anemia, and there is no reason to believe that she had a virus disease. She does not appear to have been exposed to any of the toxic substances described, or to have taken any of the drugs mentioned. She appears to have none of the hereditary or familial diseases. The only thing left is paroxysmal nocturnal hemoglobinuria of Marchiafava and Micheli.

In this particular patient there are some factors which do not coincide with this diagnosis. The first is that in the typical case the passage of dark urine takes place at night or when the patient gets up in the morning. The history here, however, mentions that hemoglobinuria was present at all times of the day. Another factor is that in a typical case one notes leukopenia and thrombocytopenia, whereas this patient had a normal leukocyte count except for slight neutropenia, and there is very little thrombocytopenia. In spite of these two atypical findings there are many features that go along with this diag-

nosis: namely, the insidious onset and the long course continuing over a period of 13 years; recurrent attacks of jaundice, apparently relieved spontaneously; and hemoglobinuria, in spite of the fact that it was present at all times of the day. The bone marrow picture conforms with this type of disease. Other features were the presence of hemosiderin in the urine, the positive heat resistance test of the blood, and the strongly positive acid hemolysis test. In spite of a few atypical features, this apparently is a case of paroxysmal nocturnal hemoglobinuria. So far as intestinal obstruction is concerned, these patients are prone to develop thrombosis, particularly in the portal system. There apparently was a suspicion at the time that she might have had thrombosis of a mesenteric vessel. The obstruction spontaneously resolved, so this does not appear to be caused by any organic lesion. So far as her mental condition is concerned, we have insufficient information to draw any conclusions. Her main problem then was paroxysmal nocturnal hemoglobinuria associated with hemolytic anemia.

Doctor Pinero: At autopsy the chief interest in this patient revolved around the evidence of hemolysis and urinary infection. The sclerae were icteric, and the liver, kidneys, lymph nodes, and bone marrow were the site of brown pigmentation. The pigment was granular and gave a positive Prussian blue reaction, characteristic of hemosiderin. In the kidneys the deposit was in both the tubular cells and the interstitial tissue. In the liver the pigment was contained chiefly in the Kupffer cells, while in the lymph nodes and marrow it was seen in the histiocytes. Both kidneys contained many abscesses throughout the parenchyma. The renal pelves, the ureters, and the bladder contained purulent fluid.

The immediate cause of death was given as acute suppurative pyelonephritis. Underlying disease was paroxysmal nocturnal hemoglobinuria of Marchiafava and Micheli.

Dr. F. W. Madison: This patient had some mental disturbances, but they were unrelated to this hematologic situation. Doctor Gani has done an excellent job in differential diagnosis and in bringing this case to a clinical conclusion, because this is a very unusual type of hematologic disorder. We have seen only two such cases here, and until 1950 the total number of cases reported was 46; however, there have been more added since that time.

The condition was probably described[1] before Marchiafava's original description in 1911.[2] However, he has been given credit for the original description, and Micheli's more elaborate description in 1931[3] is the basis for the modern medical concept of the clinical manifestations of the disease. This unfortunately does not represent well some of the most characteristic features, but it does fall into this category, even though our tests at that time were not as accurate as they are now. The diagnosis of aleukemic leukemia was probably not made here, but these patients are usually seen by many clinicians before the final diagnosis is made. They often come in after splenectomy and with several previous clinical diagnoses.

The most striking feature in this patient was the great difficulty we had in giving her blood. The reactions which she had to the administration of whole blood were severe and violent and included, of course, destruction of red cells and the precipitation of a marked hemoglobinuria. By using triple-washed red cells (from our blood bank) we were able to give her a transfusion without severe reaction. I do not recall whether we attempted to give her plasma alone, which would have been an interesting procedure, because in a certain number of these people it has been reported that the mere administration of plasma will cause hemolysis. After obtaining the washed cells, the problem of keeping her blood at a reasonable level was not as great as it had been previously. The most characteristic part of her clinical picture was the chronic anemia, which was obviously of hemolytic type. Her hemoglobin level and erythrocyte count were persistently low, with a high reticulocyte count and a normoblastic hyperplasia in the marrow. This picture is characteristic of all hemolytic anemias.

Her course was periodic, which gives rise to the term paroxysmal in the descriptive name of the disease. That too was characteristic, although in this instance we did not know what, other than blood transfusions, precipitated the hemolysis. In another patient we have been able to demonstrate that the administration of iron will do so. This is a fact which has been demonstrated in a number of other instances. The laboratory tests which were done to establish a diagnosis in this individual would perhaps be augmented

at the present time by additional methods of observation. This condition still remains one which is unusual because it is difficult to define in terms of actual mechanism of hemolysis, and it is one in which laboratory tests are not entirely definitive and do not establish the diagnosis by themselves. The diagnosis still has to be made on the basis of clinical tests and laboratory findings.

The most interesting and probably the most important part of this entire syndrome is the mechanism of hemolysis about which there has been a great deal of speculation. I believe that that process still resides chiefly in the field of speculation, although Doctor Claudon may not agree with this statement.

The diagnosis of leukemia was obviously erroneous, but remember that when these patients present themselves they have a very severe anemia and sometimes involvement of the granulocytic series as well. There is often granulopenia and even some evidence to indicate that there is actual involvement of the granulocytic series and also the platelets in this lytic process. In other words, a total involvement of marrow cells occasionally appears. The other patient we have under observation is rather an extraordinary one, who has survived the usual splenectomy (and splenectomy is a real hazard for these people) ; she has survived a pregnancy at the age of 42; she has survived radical gastric resection for a large gastric ulcer; she has survived innumerable transfusions; and she has survived our experimental efforts with iron to see if we could precipitate hemoglobinuria, which we succeeded in doing. Now she has gone on to what one might call a quiescent phase: she has not required transfusions in at least five years. She is feeling very well and may have become totally quiescent or recovered, if such a thing is possible.

Doctor Pinero: May we now hear from Doctor Claudon?

Dr. Dann B. Claudon: It would be a foolish man indeed who disagreed with Doctor Madison, particularly in the hematologic field. I would like briefly to remark about the laboratory tests and to emphasize that while the diagnosis can be detected from the clinical evaluation of history, physical examination and observation of the urine and such data, this is still a diagnosis which can be scientifically established only by a variety of laboratory tests. One of the most interesting aspects, probably unrelated to her disease itself, is the fact that when she was studied in 1947 it was found that she was Group B and a true Rh-negative. However, in spite of the innumerable transfusions which she had received since 1934 and which she subsequently received, she never developed Rh or hr isoagglutinins, so that there must have been something wrong with her reticuloendothelial system in addition to the defect in her erythrocytes. Doctor Gani has done a splendid job in differentiating the disease under discussion from other forms of hemolytic anemia. In this patient, as he and Doctor Madison pointed out, splenectomy was of no value. We might add that the use of ACTH or steroids is also of no value in managing this disease.

The defect is not clearly understood. However, Hartmann and his group at Nashville[4] have recently shown clearly that there is insufficient cholinesterase in the erythrocyte stroma in this disease. This appears to be an important factor, inasmuch as when cells with normal cholinesterase levels are transfused into these patients no hemolysis results. Crosby[5] pointed out that there is an abnormal sensitization to thrombin in this disease and has used this observation in relation to the so-called Crosby thrombin activation test. This observation has pointed toward the use of anticoagulants. Bishydroxycoumarin (Dicumarol) and warfarin (Coumadin) have been of great benefit in the management of these patients and have on occasion terminated a hemolytic crisis. Thus there is involvement of the coagulation system, and the question as to whether there is some related abnormality in thrombin and cholinesterase is being studied at the present time. Of the tests that were employed in this patient, examination of the peripheral smears, the urine, the serum, and the morphologic studies on the erythrocytes were of some help, but the definitive study was the acid hemolysis test. The heat resistance test, which was positive in this patient, is not a specific test because it may also be positive in other hemolytic anemias, particularly the parasitic types such as malaria. Therefore it cannot be used alone and, in fact, has been discarded.

Today the best tests available for confirming the diagnosis are the thrombin activation test and, if the determination is available, cholinesterase in the red cell stroma.

Doctor Madison: It is an unusual situation that in this type of patient the large amounts

of hemoglobin in the plasma which subsequently pass through the kidneys into the urinary tract do not seem to have the same deleterious effect upon the kidneys that excretion of hemoglobin seems to have under some other circumstances. Doctor Claudon might want to discuss that. These patients do not develop renal insufficiency in the sense that it appears under certain other circumstances where acute hemolysis takes place.

Doctor Claudon: It has been established that hemoglobin itself is not toxic to the renal cells, therefore in so-called hemoglobinuric nephrosis there is in addition to the presence of hemoglobin some other injury to the cells; possibly this is on the basis of ischemia, inasmuch as there is definite impairment in the circulation of such patients.

Doctor Madison: Doctor Claudon, do you have any opinion about the importance of properdin in the diseases of the hemolytic group?

Doctor Claudon: I was not aware that I was going to be queried on such involved topics, therefore the only response that I can make at this time is to say that it has been demonstrated that complement, and properdin, which is one of the minor constituents of complement, cannot be responsible for the changes in the disease. The basic defect is one within the stroma of the red cell; the changes in the plasma are apparently secondary.

Doctor Reza Soltani: What about the giving of alkalis to this type of patient?

Doctor Madison: I cannot recall that we have ever done it. It has been done, of course, and it would hypothetically be a proper means of approach to the clinical management. Actually, the experience has not been very satisfactory, although it does seem to control hemolysis at the time. It seems to be followed in some recorded instances by an increased production of the cells which are abnormal. One must remember that in this condition not all of the red cells are susceptible to the hemolytic factor. It is only a proportion of them, and if the proportion is not high, then the clinical situation is not particularly difficult. However, if the proportion of abnormal cells becomes unusually high, there is a serious problem.

This situation is said to occur after the use of alkali. Therefore it is not considered to be very wise therapy.

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A COMPARISON OF THE STANDARD RADICAL MASTECTOMY WITH THE CLASSIC HALSTED

Raymond M. Dion, M.D., Gary Welsh, M.D., and Elmer B. Miller, M.D., Grace Hospital, Detroit.

Abstract from *Journal of the Michigan State Medical Society* 59:1712 (Nov.) 1960.

From the files of Grace Hospital, Detroit, 325 cases of carcinoma of the breast were studied. Seven patients were not operated upon, leaving 318 cases for the present report.

Operations were divided in simple mastectomy, radical mastectomy done in less than three hours (standard radical) and radical mastectomy done in three to five hours (in accordance with Halsted's principles). Cases in each division were then classified in clinical groups, A, B, C, D, according to Haagenson's clinical classification, and the five-year (Haagenson's groups A, B, C) was exactly the same survival tabulated for each. It was found that the five-year survival for the operable group of patients (57 per cent) for 128 patients treated by simple mastectomy, and 104 patients treated by standard radical mastectomy. However, in forty-six patients treated by radical mastectomy done in three to five hours and appraised to be of the Halsted's type, the five-year survival was 76 per cent.

It is concluded that the time and efforts spent to accomplish a complete and meticulous radical mastectomy might be *one* of several contributing factors to a better five-year survival.

Transitions—A Focus for Prevention

By A. B. ABRAMOVITZ

Madison, Wisconsin

MODERN LIVING is very fast, very complicated and quite stressful for many people. Many persons will be hurt in the process of growing up under present-day conditions. Others may fail to develop their best potential under these trying conditions.[1]

The resulting emotional, behavioral and developmental problems present a variety of symptoms. Sometimes the difficulties are mild, but regrettably they can often be serious. Public concern has been aroused and people feel something must be done to improve the alarming situation.

When there is so much urgency because of the high incidence of problems, however, preventive efforts may be lost in the shuffle, or receive minimal attention. The fact that most adult difficulties begin in childhood underscores the importance of preventive efforts.

Certain stresses are common to all persons at transition points in the life cycle. This provides the basis for a promising preventive approach. It is important to identify these crucial points and to concentrate preventive efforts around them, much as people seek immunizations and build resistances in themselves when threatened by communicable diseases.

What are some of these important transition experiences? They include the following junctures: when young people get their first jobs; when they court and get married; when they expect and have babies; when babies are being weaned or toilet-trained; when a child is about to leave home to go to school for the first time.

No one can say that any one of these transitions is harder or more significant than any other. Ideally they should all receive equal attention and understanding. None of them receives remotely enough at the present time —at least not in terms of the all-important personal meanings, feelings, and attitudes which are automatically involved in transition experiences.

Mr. Abramovitz is the Director of the Division of Child Guidance, Wisconsin State Board of Health, Madison.

In its primary prevention programs for emotional health, the State Board of Health has been exploring ways in which to bolster as many people as possible during these common transitions. In order to devise valid methods, it is first necessary to study the nature of these transitions and how people generally react to them. When children are involved, such study will necessarily include parents and teachers. The Board of Health program is not only making such explorations but also is trying to follow up by applying the insights gained to a variety of local health services.

Expectant Parenthood and *Home–School Transition* have been the core of special efforts for a number of years. We must, however, limit the present discussion to home-school transition. This is "one of the first important role changes in the growing-up process."[2] In the Wisconsin program it has been approached through a variety of methods. The following are examples: (1) Fathers and mothers of children who are about to enter school for the first time, are organized months ahead in discussion groups for anticipatory guidance. The leadership of mental health consultants is provided. Children and teachers are included in these readying-for-school procedures. (2) Volunteer women are brought into kindergartens twice a week to read to subgroups comprising about five children each. The books are carefully chosen for their pleasure-giving and literary qualities as well as the meaningfulness of content for children at an age when they are trying to integrate a wide range of experiences at a very fast pace.

These "reading mothers" help to cushion the jump from home to school. The pleasant relationship between the "reading mothers" and the children is maintained all year and is channeled through the reading-language medium. It is assumed that for many children this will be a very positive conditioning for all later academic learning—which depends so heavily on language, communication, and positive relationships with adults.

Unfortunately, much more is known about pathology in school learning and adjustment than about the preventive and health-building potential of schools.[3] Projects such as this may help "the one institution of society through which each of us must pass" to realize its "potentiality for directing, reinforcing or correcting mental health."[1]

More recently, explorations have been initiated to find out how to improve all school-readiness and "roundup" programs. In particular, efforts are being made to learn what the whole child (soma and psyche) needs in order to tackle his big move from home to school in such good fettle that every possible basis for trouble is avoided or reduced. This is an ambitious preventive venture. To succeed it will need the support, wisdom, and co-working of the whole community. The physician can be an important part of this effort through his specialized understanding of the development and needs of children. Possible gains are considerable, hopefully in direct ratio to the great dilemma of the nation's No. 1 health problem.[4]

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PSYCHIATRIC PROBLEMS OF AGED LINKED WITH PHYSICAL ILLS. The most common psychologic and emotional disturbances in the aged usually are associated with physical illness or loss of physical and mental efficiency, according to an article in the September issue of the *Journal of the American Geriatrics Society.* Thus the family physician who has the first opportunity to see the patient should be able to recognize the nature of the latter's mental disorder, to evaluate and treat it, or refer him elsewhere for care.

Author of the article is Dr. Alvin I. Goldfarb, chief of the Department of Psychiatry and Neurology, Home for Aged and Infirm Hebrews of New York, and consultant on services for the aged, New York State Department of Mental Hygiene.

Impairment of intellectual functioning, defective memory, disturbance of orientation for time, place or person, and lack of adequate comprehension of situations and events are typical signs of brain damage, Doctor Goldfarb says. He suggests a series of simple questions and other tests which will help the physician detect and assess the severity of the chronic brain syndrome characteristic of old age.

"It is important to differentiate between the various types of behavioral disorders in older persons, despite their age and seeming short life expectancy," the author concludes. "Some of them have clear-cut chronic brain syndrome which can be diagnosed quickly and easily by the brief questionnaire described here, which includes tests for time, place, person, memory and intellectual powers. Evidence of depression and of paranoid states can also be readily elicited, and careful study will enhance the possibilities of identification and successful treatment. By thorough examination systemic diseases which might otherwise escape notice can be detected; appropriate treatment will decrease the behavioral disorder.

"The proper diagnosis of disordered behavior in an aged person may convert a seemingly insoluble problem into one at least partly remediable, to the delight of the patient, his family and the physician."

Editors
HARRY BECKMAN, M. D., Marquette University
F. E. SHIDEMAN, M. D., University of Wisconsin

COMMENTS ON TREATMENT

Spirolactone Diuretics

By JAMES L. WAY, M.D.

Madison, Wisconsin

A GROUP of steroidal 17-spirolactones recently has been developed which are potent inhibitors of the renal electrolyte effects of desoxycorticosterone and aldosterone. A few spirolactones of possible major clinical importance are: SC-9420 (spironolactone, Aldactone), SC-5233, SC-8911, SC-9456, SC-8109 and the more potent isopregnenolone-21-carboxylate, SC-11927.

The spirolactone diuretic agents are not diuretics *per se*, but are believed to exert their effects by the competitive inhibition of aldosterone. Therefore, these antagonists are effective only in the pesence of endogenous or exogenous aldosterone or aldosterone-like steroids, and their effects are equivalent to those observed upon the acute withdrawal of exogenous aldosterone or suppression of endogenous aldosterone, i.e., increased excretion of sodium, chloride and water, and decreased excretion of potassium, titratable acidity, phosphate and ammonia. Spironolactone and SC-11927, the more promising spirolactones, are relatively ineffective in endocrinological tests for cortisone-like, estrogenic, androgenic, anabolic and progestational activities. The toxic manifestations seen with the use of these two spirolactones have not been serious.

In regard to their therapeutic usefulness the steroidal spirolactones, under appropriate circumstances, are oral diuretics with a slow onset of action, sometimes taking a week before a maximal diuretic response is attained. Although these aldosterone inhibitors may induce a satisfactory diuretic response when employed alone, in general, they are only moderately effective when used as the sole diuretic. Frequently a greater and more rapid diuresis can be accomplished by the more conventional diuretics. The spirolactones are not as potent as the benzothiadiazine or mercurial diuretics; however, they can sustain a slow diuresis over a long period of time without the patient becoming refractory to them, as is not uncommonly the case with the older diuretics; and frequently they are effective in individuals who have become refractory to other agents. Their therapeutic effectiveness is enhanced by combination with other diuretics, such as chlorothiazide and/or glucocorticoids, e.g., prednisone. The addition of a spirolactone not only may enhance the natriuretic effect of other diuretics but also may antagonize the tendency of conventional diuretics to induce a kaliuretic response and hypokalemia. The spirolactone diuretics should prove to be useful in treating various types of edema and may be of value in the management of hypertension and primary aldosteronism. The usual daily dose of spironolactone is 300 to 500 mg. administered in divided dosage at 6-hour intervals.

CARCINOMA OF THE THYROID IN A MEDIUM-SIZED GENERAL HOSPITAL

PEDRO CUEVAS, M.D., and JOSEPH A. WITTER, M. D., Highland Park General Hospital, Detroit. Abstract from *Journal of the Michigan State Medical Society* 59: 1712 (Nov.) 1960.

After reviewing reports in the current literature from some of the large clinical centers of a relatively high incidence of carcinoma of the thyroid, we were left with the distinct impression that such is not the case in the cross section of the population which presents itself at a medium-sized general hospital. It seemed plausible to us that patients with thyroid disease might tend to gravitate toward a well-known clinic or university medical department from a radius of several hundred miles, and this concentration of cases gives the erroneous impression that thyroid carcinoma occurs with equal frequency throughout the country.

Reviews of large numbers of thyroidectomies for all causes from such centers yielded a malignancy incidence of 6.5 per cent, while thyroidectomy for discrete adenomas produced an average of 16 per cent of cancers.

During the five-year period of 1955–1959 at Highland Park General Hospital, there were 348 operations upon the thyroid gland. Of these, malignancy was found in seven, an incidence of 2 per cent. These occurred almost exclusively in nontoxic nodular goiters. Histologically, they were of a low order of malignancy and occurred primarily in female patients of all age groups. Treatment was aggressive when cervical nodes were involved and was conservative when the disease was apparently limited to the thyroid.

Admittedly, this is a small series, but the incidence of 2 per cent is about one third of that of reported series and tends to substantiate our impression that thyroid cancer does not occur as frequently in our practice as it does in that of the large centers.

PROBLEMS OF THE NEWBORN

St. Mary's Hospital, Wausau—Wednesday, September 13, 1961

MODERATOR: *A. H. Stahmer*, M.D., President, Wisconsin Academy of General Practice

PROGRAM

P.M.

1:00 Registration

1:30 PROBLEMS OF THE NEONATAL PERIOD: *Robert M. Kass*, M.D., Wausau

1:40 DIAGNOSIS AND MANAGEMENT OF FETAL DISTRESS IN LABOR: *John Evrard*, M.D., Milwaukee

2:00 INFLUENCE OF ANESTHETIC AGENTS IN THE NEWBORN (The Critical Three Minutes After Birth): *J. W. Bookhamer*, M.D., Milwaukee

2:20 INFANT APPRAISAL AND IMMEDIATE POSTPARTUM CARE: *Kenneth J. Winters*, M.D., Milwaukee

2:35 RESPIRATORY DISTRESS SYNDROME: Medically—*Warren Rudy*, M.D., Wausau; Surgically—*Tague Chisholm*, M.D., Minneapolis, Minn.

3:15 Questions on first four topics

3:35 Coffee break

4:00 THE Rh FACTOR AND TRANSFUSION PROBLEMS: *Rex Ruppa, M.D.*, Milwaukee

4:20 SURGICAL PROBLEMS OF THE NEWBORN: *Tague Chisholm*, M.D., Minneapolis, Minn.

4:50 INFECTIONS AND USE AND MISUSE OF DRUGS: *Thomas V. Geppert*, M.D., Madison

5:10 Questions

A TEACHING PROGRAM PROVIDED THROUGH THE CHARITABLE, EDUCATIONAL, AND SCIENTIFIC FOUNDATION OF THE STATE MEDICAL SOCIETY

Co-Sponsors: The Bureau of Maternal and Child Health of the State Board of Health and the Wisconsin Valley Chapter of the Wisconsin Academy of General Practice *

* This program provides 4 hours of Category I credit.

PRESIDENT'S PAGE

The Family of Medicine

A FAMILY WHOSE service and sacrifice to the cause of medicine in the last year has aroused gratification and admiration in us all is that of Dr. E. D. Sorenson. Doctor Sorenson's capable leadership and work, and his family's loyal support and concern for his purpose and medicine's constitutional purpose is exemplary. I would like to share with you some of my thoughts about families, his and mine and yours, and the family of medicine.

I am not going to point out medicine as "one big happy family." The would be romantic, foolish, worst of all, useless. But that oldest of all institutions, the family, does embody certain characteristics which I think would be worth supporting, reinstating, and preserving in our professional organizations on every level.

What characterizes a family? Is it the material dependence of children upon the breadwinner, the psychological dependence of children upon parents, or parents on each other? Is it the sense of responsibility father and son, mother and daughter feel alike, to the family's standards and goals? Is it the concern the older members feel for the young, or eventually, the young feel for the old?

Is it the pride a father feels in the achievement of a son, or the son in his father? No, the essence of a family is not grounded in one alone, it is by all these things—responsibility, dependence, concern, pride and purpose, that a family defines its unique character and spirit.

A family's basic purpose—to survive, and when that worry is allayed, to live, and make the world better by having lived in it for awhile—this basic purpose is not so very different from our purpose as stated in our constitution: "That this society is to become more capable and honorable within itself, and more useful to the public, in the preventing and caring for disease, and in prolonging and adding comfort to life."

Of necessity, a family's first concern is to survive; then they are able to serve mankind. Just so, the medical counterpart of the small family unit, the individual practice, must be allowed to survive, in order to best serve suffering mankind.

Some of you have completed your fifty years of dedicated service. You are men who know well the meaning of these lines:

> "How dull it is to pause,
> To rust unburnished, not to shine in use!"

Your continuing service epitomizes a great lesson society evidently has yet to learn about the forced retirement of the individual—the individual who by his very nature must exercise his creative and productive powers until they are totally extinguished.

Ulysses had to admonish Achilles about what you already know: "Perseverance my lord, keeps honor bright!" To simply extend the carrot of social security cannot, and will not, satisfy man's need of fulfillment in the larger sense. Whether you are now entering the House of Medicine, or leaving it, we know that the loyalty and honor you feel as a member of this family comes only from seeking to fulfill its high purpose.

Consider each member's responsibility to standards in a family, to each other and to mankind. We must honor that value above all others in our individual practices. If we are to serve as well as we possibly can, we must fulfill our responsibilities to our state, national and world medical organizations with the same commitment we feel to members of our personal family.

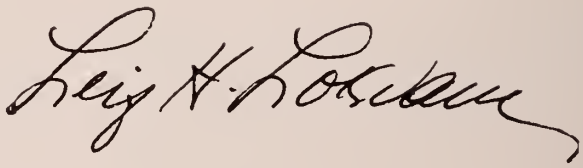
We must lay plans to extend medical knowledge, and to elevate the standard of medical education. We must work to secure the enactment of just medical laws, and we must seek to enlighten and direct public opinion about the great problems of medical service and legislation.

Though we must assume a family responsibility, we may enjoy a family pride. After another year of laboring in our various fields at our individual tasks, the state medical family gathered once again in May. Our annual coming together in convention is much like the gathering of our forebears in county and state fairs, and evokes familiar and nostalgic thought. Here in the spirit of the fair we prize the outstanding demonstrations of scientific research, testimonies to the advance of medical science.

Our family of medicine is unique in many ways, but its outstanding quality is the manner in which it transcends all boundaries and embraces all human beings. Where society is generally limited by groups of one race, churches of one faith, political organizations of one philosophy, nations of one ideology, the family of medicine knows no limits. All races, all faiths, all political philosophies join in common effort, and all national ideologies fade in a common interest and concern for the well being of the family of man. All human creatures are familiar with the same absolute problems. For suffering and pain, disease and distress, living and dying, have no boundaries, no racial, religious, or political qualifications. Nor can they be ministered to but on the broad humanitarian level that is the tradition of the medical ministry.

And so it is natural that we direct our thoughts to the world family of medicine, and its united effort through the World Medical Organization, which is now showing a torn and turbulent society the key to unlock iron curtains and the path to cross racial, color and religious barriers. Perhaps our united effort to mitigate physical pain and mental illness will be the ultimate means of relieving the more terrible, ill-defined, fatal pain of universal distrust, suspicion and war. Our ultimate cure could be universal peace. Let us take courageously this road that offers hope for tomorrow in the continued service to mankind by the family of medicine.

—Presented at the State Medical Society Annual Dinner, May 3, 1961, Milwaukee.



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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Who Really Speaks for the Church?

THE GENERAL BOARD of the National Council of the Churches of Christ in the U.S.A. recently adopted a resolution urging "legislation which will extend the benefits of Old Age, Survivors' and Disability Insurance to include health care for retired aged persons." In an admirable statement developing the Christian's duty to care for the sick and needy, the National Council paid tribute to the advantages of voluntary health care, but concluded that too many people, particularly in the age group over 65, were left unprotected by private prepayment and insurance plans, and therefore the Social Security system was the only workable mechanism.

No medical man would quarrel with the intention of the National Council, nor with its noble statement of principles. As a profession, we are devoted to the sentiment so beautifully enunciated by the National Council: ". . . sharing God's purpose that mankind should have health, a ministry of healing has become an inherent aspect of a civilized and humane society."

Because of our kinship of purpose and our subscription to a common orientation of social service, as doctors, we are bewildered by the inexplicable abdication by the National Council of sound principles of medical care for the needy in favor of measures that groups most intimately involved in rendering health service eschew. While it acknowledges the desirability of private prepayment plans, health insurance, group plans, and all the other mechanisms that are successfully supplying medical care to the aged and the needy, the Council seems to have written them off without any regard for their progress, for their potential, or even for the alternatives to tax-supported medicine.

It may be a coincidence that while Nelson Cruikshank of the AFL-CIO is boasting that he had personally written a paragraph of the resolution adopted by the National Council, the AMA, through Dr. F. J. L. Blasingame, is pointing out that the resolution was adopted without a hearing from the representatives of medicine, nor from other groups opposed to Forand-type legislation. It is curious that the resolution should dispose of the entire problem, which is admittedly a tough one, with such cavalier ease.

The National Council is an organization of considerable opinion-molding influence. Its resolutions are not to be taken

lightly. Because of its great influence, the Council also has a vast responsibility to resist becoming an echo-chamber for the doubtful propaganda of those who have a political ax to grind.

Perhaps the General Board of the National Council acted judiciously in adopting its resolution dealing with the economics of medical care for the aged. Perhaps it believed it represented the ideals to which its members are committed. Many church members, on the other hand, strongly believe that Forand-type medical care will negate the very ideals of succoring the aged and the needy. They believe that united, socially planned action, such as the National Council endorses, can be other than politically controlled, give-away medicine.

It would be well for the National Council to reconsider its stand. The issue is too important, too far-reaching for as influential a group as this one to reach a half-considered conclusion. We urge that communicants of member churches inform the National Council of the Churches of Christ of their opposition to Forand-type legislation, and the reasons for their opposition. It is to be hoped that if sufficient sentiment opposing the resolution is heard, the National Council will see the error of a formal resolution that gives special pride only to the lobby of the AFL-CIO.

Welcome Assist

AT LONG last somebody has come forward to do for doctors the kind of public relations job doctors should have done for themselves long ago. Mead Johnson and Company deserves the profound appreciation of the medical profession for its series of institutional advertisements now appearing in national magazines dealing with the role of the physician in modern society.

Cleverly conceived and artfully prepared, the advertisements are designed to "strengthen the physician-patient relationship through increased public understanding of the doctor and the diversity of roles which he performs in American life today." At the same time, the ads emphasize the fact that the key to continued excellence in medical care is the system allowing free choice of physician.

While the copy is generally flattering to doctors, the ads seek to remove both the idealized romanticism as well as some of the gratuitous criticism that have been built up around the concept of the physician in this country. The entire series is tied together by this recurring theme: "Is it any wonder that medical practice is a personal service of greater than average importance to all of us? Is it any wonder that it demands the highest standards of professional conduct and competence? . . . It is the kind of service relationship which requires respect and confidence and the kind of individualized attention which cannot possibly be reduced to legislated regimentation."

The Mead Johnson ads in this series carry no product promotion.

While the medical profession may be reticent to advertise itself, this kind of explanation of our profession is nevertheless vitally important at this crucial period in our history. We cannot sit still and permit those who would reduce doctors to the status of civil servants build a hateful popular conception of us that has no relation to reality. On the other hand, it must be regretfully admitted that our own efforts to improve the public's understanding of our position has often been woefully inadequate, misdirected and clumsy.

The public relations problem of the medical profession requires a slick, knowledgeable approach. It requires the suede-shoe technique of advertising agencies accustomed to hard-sell in the market-place; and it needs the restraint of a sponsor who entertains a high regard for the dignity of our profession.

All of these things have been provided by Mead Johnson in this series of ads, for which the company is to be highly commended. At the same time it is to be hoped that other companies supplying the health needs of the country, as well as our own organization, take a cue from the effect of the Mead Johnson ads and put forth a similar effort while there is still time.

The editorial "Un-American Activities" appearing in the June issue produced a number of comments—some favorable, some unfavorable. Because the Journal is a monthly, there is little opportunity for the timely publication of reader comments. Thus, it is not our intent to publish statements other than the one which follows, and this is a specially-done "tip-in."

—C.H.C.

TO THE MANAGING EDITOR

Over the years, we have learned to take for granted the integrity of content that has been characteristic of our state's Medical Journal. We have grown accustomed to straightforward presentation of news germane to the profession; to scientific articles, soundly researched, thoughtfully edited; to advertising that reflects the Society's insistence on truthful presentation.

To take all this for granted was a natural reaction to the publication's record as a communications medium dedicated to serving the physician in the professional context of his life.

However, our confidence in the Journal's integrity of content was shattered the day we received the issue of June, 1961. The negative impact could not have been greater if the issue's lead article had advocated the efficacy of a notorious quack remedy.

We refer specifically to the editorial titled, "Un-American Activities."

An exercise in the area of political opinion —having no connection with the professional purpose of the WISCONSIN MEDICAL JOURNAL —this editorial was simply a violent attack on an organization called the John Birch Society.

Our opinions of the John Birch Society and countless other subjects are a part of the "private-citizen" side of our lives. We cherish the right to express these opinions openly as *free individuals.*

It does not follow, however, that a member of our State Medical Society has the right to use the Society's professional publication to express his personal opinion on a subject that has nothing to do with the practice of medicine.

In our state, there is no shortage of outlets for an editorialist to express himself on political subjects. However, the Medical Society of our state has just one official organ, the WISCONSIN MEDICAL JOURNAL. The opinion expressed in its pages is interpreted as the official view of the entire Society—not simply as the opinion of one man. And when such opinion is purely political—having nothing to do with the practice of medicine—it represents, we believe, an abrogation of the editorial objectives and policies to which we all subscribe.

PAUL NATVIG, M.D.

JAMES A. SCHELBLE, M.D.

THE MEDICAL FORUM

Physicians Urged To Take Immediate Action In Opposition To King–Anderson Legislation

Hearings on the administration-backed King Bill (H.R. 4222), to provide medical care for the aged under the Social Security system, are expected to begin in Washington in the latter half of July.

In view of this, the Committee on Health Economics of American Life of the State Medical Society has made the following requests:

For individual physicians:

1. Write your U.S. Representatives and Senators as soon as possible, expressing opposition to the King Bill and its Senate counterpart, the Anderson Bill (S. 909).
2. Ask friends to write their Congressmen expressing their views on this legislation.

For county medical societies:

1. Prepare a statement in opposition to the King Bill and send it to the Congressman of your district with the request that he have it entered into the Congressional Record of hearings on the bill.
2. Contact at least five local non-medical organizations and urge them to submit the same type of statement.

A significant Wisconsin development on King–Anderson legislation is the passage of a resolution by the Wisconsin Hospital Association stating that it is "opposed to inclusion of a compulsory health insurance program under the social security mechanism and opposes King–Anderson or Forand type legislation."

The Committee on Health Economics of American Life, in its June meeting, stressed the importance of informing Congressmen of the views of medicine and non-medical organizations and individuals prior to and at the time of the hearings.

Kerr–Mills Proposal Advanced By 93–0 Vote In Assembly

Implementation of the Kerr–Mills law in Wisconsin was advanced a major step June 20 when the State Assembly engrossed Substitute Amendment 3,A to Bill 550,A by a vote of 93 to 0.

This engrossment represents preliminary approval in the Assembly, although the bill can still be debated by the Assembly after it is returned to the floor from the Joint Committee on Finance.

Substitute Amendment 3,A represents the latest refinement of the health care for the aged measure supported throughout this session by the State Medical Society.

It is essentially similar to Bill 550,A, and provides for the same appropriation: approximately $10,400,000 each two years for Wisconsin's share and $11,600,000 in matching federal funds.

With the state cost at $5,200,000 annually, it is interesting to note that the Kerr–Mills law brings Wisconsin an additional $2,672,000 each year for its Old Age Assistance program.

This frees an equal sum, which Wisconsin ordinarily budgeted for its OAA system, which could be applied to the proposed additional Kerr–Mills legislation. This would bring the total of new tax money

(Continued on page 391)

Medical Society Requests Time At House King Bill Hearings

The State Medical Society has requested an opportunity to present the position of Wisconsin medicine on the King Bill at the hearings before the House Ways and Means Committee.

If the request is granted, Dr. Robin Allin, chairman of the Society's Committee on Health Economics of American Life, will make the presentation.

Doctor Allin, a specialist in internal medicine, has been chairman of the HEAL committee since September 1960.

ROBIN ALLIN, M. D.

List Ways And Means Committee Members

The House Ways and Means Committee, which will conduct the hearings on the King Bill, is regarded by some political experts as the single most powerful group in Congress.

Its power stems from a clause in the Constitution that all bills for raising revenue must originate in the House of Representatives. The Ways and Means Committee is the House panel that handles such measures.

Fifteen Democrats and 10 Republicans make up the Committee. Here is a rundown of the members:

DEMOCRATS

Wilbur D. Mills, Arkansas; Cecil R. King, California; Thomas J. O'Brien, Illinois; Hale Boggs, Louisiana; Eugene J. Keogh, New York; Burr P. Harrison, Virginia; Frank M. Karsten, Missouri; A. Sydney Herlong, Jr., Florida; Frank Ikard, Texas; Thaddeus M. Machrowicz, Michigan; James B. Brazier, Jr., Tennessee; William J. Green, Pennsylvania; John C. Watts, Kentucky; Al Ullman, Oregon; James A. Burke, Massachusetts.

REPUBLICANS

Noah M. Mason, Illinois; **John W. Byrnes, Wisconsin**; Howard H. Baker, Tennessee; Thomas B. Curtis, Missouri; Victor A. Knox, Michigan; James B. Utt, California; Jackson E. Betts, Ohio; Bruce Alger, Texas; Steven B. Derounian, New York; Herman T. Schneebeli, Pennsylvania.

DR. E. VINCENT ASKEY, center, then president of the American Medical Association, was the main speaker at the Spring Clinic Day of Mount Sinai Hospital, Milwaukee, on May 18. He spoke on current developments in medicine and social and political problems related to the provision of medical care for the aged, indicating that the Kerr–Mills approach offered the proper solution. Shown above with Doctor Askey are Dr. Marvin Wagner, chairman of the program, left, and Dr. Joseph Shaiken, chief of staff, on the right.

Write Your Congressman On The King Bill

The names of Wisconsin's representatives in Congress are printed below for use by physicians to write to their congressman on the King Bill (H.R. 4222) and to express their views on the concept of federal intervention in medicine as represented in the medical care under social security approach.

The number of the congressional district is given preceding each name and the party affiliation after each name.

1. Henry C. Schadeberg (R)
2. Robert W. Kastenmeier (D)
3. Vernon W. Thomson (R)
4. Clement J. Zablocki (D)
5. Henry S. Reuss (D)
6. William K. Van Pelt (R)
7. Melvin R. Laird (R)
8. John W. Byrnes (R)
9. Lester R. Johnson (D)
10. Alvin E. O'Konski (R)

Following is the address and form of salutation to be used in writing your Congressman:

The Honorable John Doe, M.C.
House Office Building
Washington 25, D.C.
Dear Representative Doe:

FIVE REASONS WHY MEDICINE IS OPPOSED TO KING–ANDERSON LEGISLATION

1. It is totally unnecessary. The Kerr–Mills Law can do the job.
2. It would mean poorer, not better health care for the aged, with government employees telling hospitals how to operate; telling nursing homes what they could and could not do; and, eventually, telling doctors what drugs and treatment they could provide their patients.
3. It would lead to the decline, if not the end, of private health insurance, which has made such great strides in recent years.
4. It would mushroom into compulsory national health insurance for every American, as time went by. What would start out as socialized medicine for the aged would eventually become socialized medicine for every man, woman and child in the country.
5. It would be staggeringly expensive. Social Security taxes are already scheduled to reach nine per cent of payroll by 1969. This would increase them further. It is well to remember that such bills as these are irreversible in nature. Once started—like an avalanche—they are hard to stop. The tendency is to expand them—never to contract them. As time went on, Congress would face continual pressures for more extended coverage and more elaborate benefits. Costs would rise proportionately.

Kerr–Mills Proposal Advanced By 93–0 Vote

(Continued from page 389)

that must be found down to $2,528,000.

To be eligible for benefits under the bill, an applicant must:

... be 65 years or older
... have an annual income of less than $1,500 if single or $2,500 if married
... have personal assets of less than $4,500 if single or $7,500 if married

Personal assets, as defined in the bill, do not include a home, household and personal possessions, or an automobile.

There is an additional provision where an applicant may become eligible for benefits if he has expended all of his income in excess of these limits for health services or for health insurance premiums.

The bill provides for:

... inpatient hospital care
... skilled nursing home care when authorized by a physician
... professional services of a physician or doctor of dental surgery
... outpatient services of a physician or hospital
... diagnostic services requiring X-ray or laboratory procedure

The amount of services may subsequently be expanded or reduced according to the amount of funds available, and if funds are sufficient, it may also include other benefits such as drugs or care by a visiting nurse.

Under the substitute amendment, an applicant need not be subjected to a welfare type of investigation. Application may be made and accepted on the basis of a sworn statement. The welfare department may do a post-audit investigation where it feels this is necessary.

Recovery for benefits paid to an applicant is permissible only after the death of the beneficiary and his spouse, unless benefits are paid incorrectly — in which case they may be recovered at any time a court judges.

Specific provision is made to require free choice of physician, dentist, hospital or skilled nursing home.

FIVE REASONS WHY THE KERR–MILLS LAW MERITS PUBLIC SUPPORT

1. The Kerr–Mills Law provides legislation under which it is possible for the first time to help every aged American who needs help to pay for health care. Its benefits, based on need and local determination, permit much broader coverage than under proposed Forand-type legislation.

2. The program is voluntary, not compulsory. It will supplement, not supplant, individual voluntary health insurance or prepayment.

3. It will be administered on a local basis. The Kerr–Mills Law leaves matters up to the States by giving them the right to set up their own programs in their own way, on the logical theory that each State knows its own particular problem better than the Federal Government does.

4. The new law is economical. Local administration, local choice of scope of benefits and method of payment, local definition and determination of eligibility, minimum Federal controls—all these mean that our tax dollars will be spent to best advantage.

The use of this approach not only guarantees that we will be helping those who need help, but that we will not be wasting tax dollars on help for those who are perfectly willing and able to take care of their own health care costs. And there are millions of these people.

5. The quality of medical care under such a plan will be infinitely superior to that possible under the social security approach. Under the new law, any type of care can be provided if the State determines the need for it. Further, the fact that Federal controls are held to a minimum allows adequate supervision of the program by physicians, and no restraints upon the doctor in the exercise of his medical judgment.

The medical profession's basic policy has always been to insure that the needy receive the same high quality of medical care as anyone else in the community. Under the Kerr–Mills Law, this can and will be accomplished.

HAVE YOU LOOKED AT YOUR INCOME PROTECTION LATELY?

Is your disability income insurance up-to-date?

To find out, apply these tests:

- *Is your sickness coverage limited to only five or ten years? Or does it cover you to age 65 as Time plans do?*
- *Does it demand total disability from the start, or does it compensate you (as Time plans do) if unable to perform the duties of your occupation for 2 to 5 years?*
- *Are you paying much more premium than you would under a comparable Time plan?*

If the answer to any of the above questions is "yes", we suggest you contact your Time representative without delay.

TIME INSURANCE COMPANY

Personal insurance sold and serviced since 1892.

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Racine Journal–Times

NEW SEAL for the Racine County Medical Society was created by Ray Krenzke, right, a Racine high school student. Dr. Joseph D. Postorino, president, congratulates the three top entrants in the photo above.

Medical Care Plans Commission Announces Election Of Officers

Dr. John Krohn, Black River Falls, was re-elected vice-chairman of the Commission on Medical Care Plans at a meeting June 17 in Madison.

Dr. John T. Sprague, Madison, was elected treasurer to succeed Dr. Nels Hill, Madison, who is currently president-elect of the State Medical Society.

Voting delegate to the national Blue Shield and AMA observer is Dr. William T. Casper, Milwaukee, and Dr. David N. Goldstein, Kenosha, is alternate. Both were re-elected.

The chairman of the commission is appointed by the chairman of the Council. Dr. E. M. Dessloch, Prairie du Chien, is the present chairman.

Dane County Foundation Announces Award Policy

The Dane County Medical Society Foundation for Medical Research has announced its policy governing the award and receipt of research grants.

Applications will normally be received before March 1 of each year, with grants up to $2,000 awarded for one year with the possibility that they may be extended to a second year upon application.

No obligatory requirements are asked of a research program by the Foundation, which does not hold itself responsible for the direction of a research project. Work results may be freely published, carrying a footnote acknowledging the Foundation's support.

WPS Figures Up For April

Wisconsin Physicians Service surgical-medical and hospital claims experience in April was notably improved over the first quarter of the year.

Additions to reserves from April operations totaled $42,592.30; thus bringing the addition for four months ended April 30 to $36,-511.69.

Total reserves at April 30 were $1,487,855.57—up $49,202.41 over March 31. This includes the operating results noted above and a $6,610.11 gain in the market value of securities.

Racine Society Has New Seal

The Racine County Medical Society has announced the winners in a contest to design a seal for the society.

Edward J. Krenzke, Racine, was the winner of the $50 savings bond awarded for first prize. Second prize was a $25 bond and third place winner received art supplies.

The contest was open to all high school students in Racine County, with the exception of sons or daughters of physicians. Thirty-five entries were received.

Judging was conducted by members of the county society's public relations committee.

The three winners attended a dinner meeting of the society to receive their awards.

Cancer Coordinating Group Reviews Current Programs

The Cancer Coordinating Committee, made up of representatives of organizations interested in the disease, met May 25 at the State Medical Society building in Madison.

The committee, which was recently re-activated, is currently surveying the activities of various organizations in the state.

Reports were heard from the State Board of Health, Wisconsin Academy of General Practice, Wisconsin Society of Pathologists, Wisconsin State Dental Society, Milwaukee Diagnostic Tumor Clinic, Milwaukee Division of the American Cancer Society, Wisconsin Division of the American Cancer Society, and State Medical Society of Wisconsin.

Committee On Cancer Approves New Film

The Committee on Cancer of the State Medical Society met May 25 in Madison.

The group previewed the film "Colostomy Examination" and unanimously approved it for showing to the public, reviewed the report to the House of Delegates presented at the annual meeting, and discussed cancer articles for the *Wisconsin Medical Journal.*

A CES FOUNDATION PROJECT . . .

Two Hundred Attend Retardation Conference

"It has been demonstrated here today that through close cooperation between the physician, parents, and community resources, progress has been made," said Dr. Reynold A. Jensen, at a conference on Medical Aspects of Mental Retardation held in Milwaukee June 21.

The conference, sponsored by the Charitable, Educational and Scientific Foundation, included sections on evaluation of the growing child, counseling and planning with the family, case presentations, and discussions of the latest research developments in the field of mental retardation.

Cooperating in sponsorship of the conference were the Wisconsin Council for Mentally Retarded Children, Inc., and the Mental Hygiene Division of the Department of Public Welfare, which provided financial support.

Cooperating agencies included the Division on Nervous and Mental Diseases of the State Medical Society, the Wisconsin Academy of General Practice, the Wisconsin Association for Mental Health, Bureau for Handicapped Children of the Department of Public Instruction, Wisconsin State Board of Health, Marquette University School of Medicine, University of Wisconsin Medical School, and Wisconsin State Board of Vocational and Adult Education (Rehabilitation Division).

Some 200 persons attended the meeting—about half physicians and the remainder parents and service agency representatives.

Doctor Jensen, professor of psychiatry and pediatrics at the University of Minnesota Medical School, citing the progress made in attitude toward retardation stated, "This conference could not have been held 10 years ago."

He went on to state that one of the main problems facing the physician was not in making the diagnosis, but in helping the parents clarify their thinking and feelings toward the retarded child.

To assist the physician in counseling and planning with the family, Dr. A. A. Lorenz, Eau Claire, discussed classification of mental levels and how these can be explained to the parents.

A MAIN SPEAKER at the Conference on Medical Aspects of Mental Retardation was Dr. Reynold A. Jensen, professor of psychiatry and pediatrics at the University of Minnesota Medical School, pictured above. The program was presented in Milwaukee on June 21.

DR. LEONARD J. GANSER, Director of the Mental Hygiene Division, State Department of Public Welfare, pictured below, was another program participant. Doctor Ganser outlined the existing resources available to physicians and parents. Some 200 persons attended the conference.

Dr. Leonard Ganser, director of the Mental Hygiene Division, Department of Public Welfare, in discussing the existing state and community resources available to aid the family of a retarded youngster, added that it is an important part of the physician's service to be familiar with these resources.

A key part of the conference involved statements by parents concerning what they expect from the physician, presented by G. I. Wallace, Madison, and two families who participated in a question-answer period on their personal experiences.

Dr. Henry Veit, Milwaukee, followed with discussion of institution care for the retarded, including case presentations from Southern Colony.

Dr. Harry Waisman, professor of pediatrics at the University of Wisconsin Medical School, explained the significance of biochemical research to the family physician.

Advancements in genetic research were explained by Dr. David Smith, associate professor of pediatrics, University of Wisconsin Medical School, and educational research was discussed by Robert Erdman, Ed.D., associate professor of education and chairman of the department of exceptional education at the University of Wisconsin–Milwaukee.

In concluding the conference, Dr. H. Kent Tenney, Madison, conference chairman, summarized: "If we have accomplished one thing, that is to do away with the attitude of 'put the child away and forget about him—nothing can be done' and replaced that with an attitude of hope, rather than hopelessness."

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Inquiries Invited

Wisconsin Public Health Council Holds Annual Meet In Madison

Over 100 members of the Wisconsin Public Health Council attended the organization's annual meeting held June 19 in Madison.

They heard speakers and panel members discuss establishment of homemaker services, reorganization of local public health organization, and the need for more qualified applicants to medical schools.

Mrs. Paul E. Rauschenbach, Paterson, New Jersey, program chairman for the Woman's Auxiliary to the American Medical Association, was the keynote speaker. She outlined the establishment of homemaker services in her community.

ESTABLISHING HOMEMAKER SERVICES was the topic of this panel at the annual meeting of the Wisconsin Public Health Council in Madison June 19. Pictured left to right are: Joseph O. Wilson, Department of Public Welfare; Dr. Irvin L. Blose, Durand; Miss Hazel Taylor, Marathon County Nursing Service; Miss Ione Rowley, State Board of Health; Miss Emma Kuehlthau, Milwaukee Visiting Nurses Association; and Mrs. Paul E. Rauschenbach, Paterson, New Jersey, Program Chairman of the Woman's Auxiliary to the American Medical Association.

Participating in a panel discussion on the same subject were Miss Hazel **Taylor**, supervising nurse, Marathon County Nursing Service; Miss Emma **Kuehlthau**, executive director, Milwaukee Visiting Nurses Association; Dr. Irvin L. **Blose**, Durand; and Joseph O. **Wilson**, supervisor, staff development unit, Division of Public Assistance.

Establishment of Waukesha County's health department was discussed by Professor Max **Kurz**, a former member of the Waukesha county board. Other comments on local public health reorganization were made by Senator Howard **Cameron**, Rice Lake, and Karl **Mohr**, Green Bay. Both participated in drafting of Bills 2, S. and 3, S. by the Legislative Council.

Dean John S. Hirschboeck of the Marquette University School of Medicine outlined the need for more qualified applicants for medical schools. Also commenting on the problem were Dr. T. H. McDonell, Waukesha, chairman of the State Medical Society's subcommittee on medical student recruitment, and Miss Margaret Fosse, director of guidance at East High School, Madison.

In elections held that day, Mrs. Alice **Sanders**, Milwaukee, was named first vice-president; Dr. C. K. **Kincaid**, Madison, treasurer; and board members Mrs. Jesse **Finch**, Stoughton; Mrs. James C. **Connell**, Pewaukee; Cliff **Engeswick**, Sheboygan; Karl **Mohr**, Green Bay; and Miss Hazel **Taylor**, Wausau.

MATERIALS AVAILABLE FROM STATE MEDICAL SOCIETY

The following materials are available from the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin, on the subjects of Socialized Medicine and Medical Care for the Aged.

1. **Motion Picture**
   Dr. Edward R. Annis, Miami, Florida, interviewed by Jerry Deane, news director of station WISC–TV, Madison, on the subject of financing health care for the aged. Suitable for showing to medical or non-medical audiences. 16 mm film, black and white, 15 minutes.
2. **Tape Recording for Medical Meetings**
   A speech by Dr. Edward R. Annis before the annual County Medical Societies Presidents' and Secretaries' Conference, March 22, 1961, on the subject of health care for the aged. This recording is for physician audiences only. 28 minutes.
3. **Tape Recording for General Public**
   An interview with Dr. Edward R. Annis and Dr. H. Kent Tenney, Madison, on the subject of health care for the aged. Suitable for playing before medical and non-medical audiences. 28 minutes.
4. **Speakers Kit**
   Background materials and sample speeches on Health Care for the Aged for use at local gatherings.

WISNIEWSKI ELECTED PRESIDENT OF WAPH

Theodore **Wisniewski**, Madison, was elected president of the Wisconsin Association for Public Health at the group's recent annual meeting.

Wisniewski is director of the Division of Water Pollution Control, State Board of Health. He succeeds Dr. G. G. **Shields**, Wisconsin Rapids.

Elected vice-president was Miss Betty **Krippens**, dental hygiene consultant at the district Board of Health office in Fond du Lac.

A VARIETY OF MATERIALS on the subject of providing health care for the aged is available from the State Medical Society and the American Medical Association. Lists of specific items are contained in this issue of the Forum. Pictured above with some of the records, tape recordings, kits and newspaper advertisements is Miss Darlene Hogan, secretary in the public relations department of the state society.

MATERIALS AVAILABLE FROM AMERICAN MEDICAL ASSOCIATION

The following materials are available from the American Medical Association, Box 5037, Chicago 80, Illinois, on the subjects of Socialized Medicine and Medical Care for the Aged.

1. Motion Picture—"Old Man Young"
   New 28 minute film on opportunities and rewards of retirement. Available through the AMA film library or on "long term" loan for: television, senior citizen clubs, civic and church groups.
2. Ronald Reagan Transcription
   Transcribed address backgrounding legislative situation and encouraging writing of letters to Congress. (Primarily for use of Woman's Auxiliaries at neighborhood coffee "klatches".)
3. Editorial Writers Kit
   Background material for use of editorial writers.
4. Pamphlets
   "Socialized Medicine and You"
   "Medical Aid for the Aged"
   "Helping Those Who Need Help"
5. Advertising Materials
   Advertising mats, in various sizes, on "Socialized Medicine and You", "Medical Aid for the Aged", and also a series of "drop-in" mats in smaller sizes on the same topics.

Radio Spot Scripts
A series of seven radio spot announcements, suitable for advertising over local radio stations.

Pre-Medical Students Awarded Scholarships By River Falls Clinic

The River Falls Clinic has established two annual scholarships for students at Wisconsin State College in that community who are majoring in pre-medicine.

The new scholarships were announced at the annual Honors Day Convocation at the college. Winners this year were Richard Ellingstad, Hudson, and Thomas Brickner, Independence.

The scholarships will be given annually to a freshman and a sophomore who are majoring in pre-medicine and who have achieved outstanding academic records and show promise of excellence in the field of medicine.

The scholarships pay full fees for the student during the year following the awarding of the grant.

National Nursing League Fellowship Program Set

The National League for Nursing has announced its 1962 Fellowship Program of advanced study for nurses.

Requirements for eligibility are: freedom to pursue a full-time program of master's or postmaster's degree study, acceptance by a recognized university, and U.S. citizenship or first papers.

Application forms are available from: National League for Nursing, 10 Columbus Circle, New York 19, N.Y.

STATE NURSING BOARD AWARDS SCHOLARSHIPS

The Wisconsin State Board of Nursing, at its annual meeting June 7, awarded scholarships totaling $31,469 to 29 Wisconsin registered professional nurses for advanced study.

The Board of Nursing appointed Miss Margaret Crump, Madison, to the Wisconsin Committee of Examiners for Nurses for a four year term and reappointed Mrs. Florence Byrne, Superior, to the Wisconsin Committee of Examiners for Trained Practical Nurses.

Health Record For Migrants

Distribution of standardized personal health records for migrant workers has been announced by Dr. James L. Wardlaw, Jr., director of the Bureau of Maternal and Child Health of the State Board of Health.

The records will be distributed through physicians, hospitals and nurses to migrant workers who do not already have them.

The forms contain space for information on immunizations, x-rays and laboratory tests, clinical conditions important in future medical care, and obstetrical record.

Purpose of the forms is to provide a continuity of medical care for the migrants. "It is important that those rendering service to these workers routinely ask the worker for his form and make the proper notations," Doctor Wardlaw stated.

Kenosha Prepayment Plan Lowers Institution Costs

For the second successive quarter, the Kenosha County Medical Society has reduced its charge for professional services to patients in county institutions.

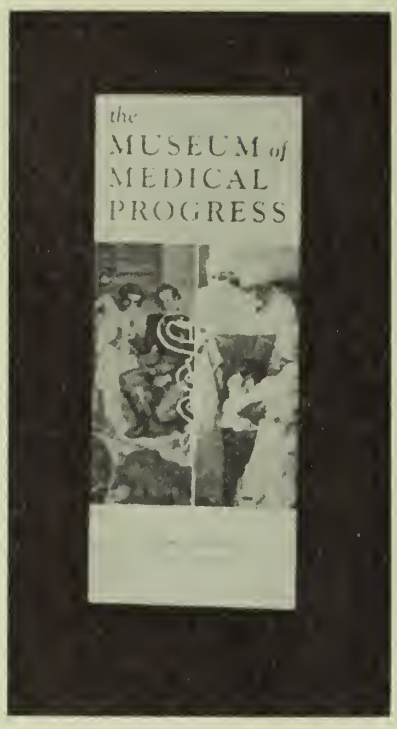
A unique contract between Kenosha Physicians Service, a non-profit division of the county medical society, and the trustees of the institutions has been in effect since June 21, 1960.

The prepayment plan covers all physician services to patients in both county institutions, as well as outpatient clinics for one of them.

Initial monthly rate, based on cost experience before the agreement, was $2,100 per month. This was lowered to $1,800 on January 1 of this year and to $1,500, retroactive to April 1.

Seat Belt Statistics

The American Medical Association has estimated that more than 10,000 lives could have been saved in 1960 out of a total highway death toll of approximately 40,000, if the auto occupants had been wearing seat belts.



A NEW BROCHURE, pictured above, describing the Museum of Medical Progress at Prairie du Chien, is now being distributed to encourage the public to visit the museum. The colorful pamphlet describes the exhibits which tell the progress of medicine over the past three centuries, gives a historical sketch of the site, and includes a map of the area. The museum is a project of the Charitable, Educational and Scientific Foundation of the State Medical Society and is operated by the State Historical Society. It is presently attracting visitors from all parts of Wisconsin and various other states.

Child Obedience Booklet Highly Popular In State

Health organizations in Wisconsin have ordered more copies of the American Academy of Pediatrics booklet, "Obedience Means Safety for Your Child," than any other state.

A large number were distributed through the "March of Medicine" radio program and a special television program over station WISC–TV in Madison. Both programs featured Dr. H. Kent Tenney of Madison and were projects of the State Medical Society.

House of Delegates Reports

Annual reports to the Society's House of Delegates appear in another section of this issue.

Data On Free Medical Care

Physicians in the United States give free medical care amounting to 685 million dollars each year, the American Medical Association reported recently.

The information was gathered from a nationwide sampling of private practitioners in a survey conducted by *New Medical Materia*, a magazine published in New York City.

The study showed that more than 98 per cent of all American physicians give free medical care, and that 60 per cent devote 10 per cent or more of their working hours to free service.

Private patients treated without charge accounted for 39.9 per cent of the total; outpatient clinic service for 22.7 per cent; and hospital ward service 26.5 per cent. The remaining 10.9 per cent involved free care to students, campers, Scouts, amateur athletes, blood donors, relatives of physicians, clergymen and emergency and charity cases.

Specialists donate 381 million dollars worth of time yearly or an average of $4,812 each, while general practitioners give 277 million dollars yearly in services amounting to an average of $3,360. The total value of free care given by physicians in this country has increased 10.6 per cent in the past five years, the AMA said.

WHERE THE MONEY GOES

Over a lifetime, the average family has an income in the neighborhood of $250,000. When you analyze where it goes, you get these results: $58,000 for housing; $48,000 for food and drink; $36,000 for taxes; $26,000 for contributions, gifts, books and dues; $24,000 for the family car; $16,000 for insurance; $12,000 for clothing; $12,000 for recreation; $12,000 for personal expenses; $6,000 for the doctor, dentist, medicines and hospital care.

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Changing Times
THE KIPLINGER MAGAZINE

State Medical Society
of Wisconsin

HOUSE OF DELEGATES REPORT MAY 1961

The House of Delegates is the legislative body of the State Medical Society. Delegates are charged with the responsibility of guiding and directing the policy and activities of the Society for the best interests of the people of Wisconsin and the medical profession.

The following pages are devoted to detailed reports of the activities of the Councils, Commissions, Divisions and the Committees of the Society, which were presented at the 120th annual meeting in Milwaukee, May 2, 3 and 4, 1961.

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REPORT OF THE COUNCIL

1960–1961

JAMES C. FOX, M.D.
Chairman

The Council, by mandate of the constitution and bylaws and by its own action, schedules regular meetings in February, May, July and November. Its Executive Committee ordinarily meets in the intervening months. It also has committees on Finance, Scientific Medicine, Economic Medicine, and Planning. Under its rules of procedure, items other than routine are first reviewed by one of the Council committees and come before the Council with appropriate recommendations. Minutes of Council meetings are published in the Wisconsin Medical Journal, and this annual report but summarizes certain highlights of material otherwise distributed.

Wisconsin Health Service, created with approval of the House of Delegates in 1960, will be under immediate direction of the Commission on Medical Care Plans and under general supervision of the Council. It is hoped that implementation of the Kerr–Mills bill in Wisconsin in its medical care aspects will be undertaken through this mechanism.

The subject of Kerr–Mills legislation will be an item of special report.

The Council has reviewed and approved the activities of the Kenosha County Medical Society in developing a prepayment plan for provision of medical services for patients in Kenosha County receiving public assistance in two local institutions. This action is taken under provision of the statutes which requires that sickness care plans of county medical societies in Wisconsin have formal approval of the State Medical Society.

During the course of 1960 the Council authorized the publication and distribution of guides relating to new laws concerning the inspection of medical records and the relationship between physicians in contract with hospitals and with each other. These two publications, known as guides to Chapter 301 and Chapter 484, laws of 1959, represented a very considerable amount of study and research, first by appropriate committees and then in detail by the Council. After sufficient experience it may be that these guides should be amplified and republished. Their distribution to new members of the State Medical Society is a routine.

Much attention has been given since last May to the scientific programs of the Society. Better to indicate the scope of its work, the Council on Scientific Work has been renamed the Commission on Scientific

NECROLOGY REPORT

The Council reports with sorrow the deaths of the following physicians since the last Annual Meeting. Members of the Society are indicated in bold face type.

Frank Jones, Oxford
Stephen Gyland, Barron
Gentz Perry, St. Paul, Minn.
C. W. Giesen, Superior
E. C. Grosskopf, Waukesha
R. L. Zaegel, Sheboygan
Woodruff Smith, Ladysmith
A. G. Pfeiler, Sheboygan Falls
E. P. Crosby, Stevens Point
M. P. Ohlsen, West Allis
L. W. Ramlow, Milwaukee
Salvatore Megna, Shorewood
S. E. Gavin, Fond du Lac
Martin Sivertson, La Crosse
A. M. Christofferson, Waupaca
E. L. Bernhardt, West Bend
Ernest Schmidt, Green Bay
Jesse Bender, Mass, Michigan
J. F. Turgeson, Belmont
J. A. Junck, Sheboygan
James Nelson, Milwaukee
C. W. Hughes, Winneconne
J. W. Lockhart, Oshkosh
G. W. Harrison, Ashland
F. M. Scheele, Waukesha
W. C. Richardson, Burlington
J. C. Frick, Waukesha
A. J. Wiesender, Berlin
L. C. Orban, Milwaukee
D. C. Atwood, Madison
M. H. Fuller, Green Bay
H. T. Callahan, Spencer
A. J. Weber, Milwaukee
F. J. Kozina, Milwaukee
J. A. Halgren, Menomonie
D. S. Van Hecke, Phillips
H. H. Meusel, Oshkosh
N. J. Knauf, Chilton
H. W. Shutter, Milwaukee
C. A. Cooper, Colfax
P. W. Snowden, Monroe
A. H. Robinson, Jefferson
Peter Bell, Madison
A. H. Carthaus, Thiensville
George Baker, Tomahawk
Florence Duckering, Sheboygan
J. P. Sprague, Minocqua
H. L. Greene, Madison
T. C. Abelman, Watertown
W. F. Vaudreuil, Rice Lake
R. G. Arveson, Frederic
Alexander Augus, Milwaukee
E. M. Poser, Columbus
H. J. Brehm, Racine
M. G. Ellinger, Milwaukee
P. J. Gilmer, Milwaukee
Joseph Jones, Cornell
M. T. McCormack, Milwaukee
J. B. Baldi, Milwaukee
H. J. Connor, Milwaukee
A. T. Farisy, Milwaukee
J. R. Whitty, Milwaukee
Russell Wilson, Beloit
Kurt Weiner, Milwaukee
H. S. Atkinson, Green Bay
E. V. Brumbaugh, West Allis
T. J. Aylward, Milwaukee
Friedrick Eigenberger, Sheboygan
E. L. Watson, Ripon
M. E. Solberg, Elroy

MEMBERSHIP REPORT

(As of December 31, 1960)

Members paying no dues		147
Affiliate members	45	
Military service members	26	
Honorary members	7	
Life members	59	
Special Service members	8	
Transfer members	2	
Total	147	
Members paying pro rata dues (military service and new members after July 1)		95
Associate members		48
Members in residency training		157
Members paying full dues		3164
Educational members		7
Total Membership		3618

Medicine and has been designated as the scientific committee of the Foundation. The Commission on Scientific Medicine will serve as coordinator of all scientific activities within the structure of the State Society and in this capacity will provide active assistance in coordinating scientific programs of others. The Council has scheduled an annual meeting with representatives of the Commission in July to review with them matters within the delegated authority of this Commission.

In this connection, the Council directs attention to a special conference planned in Madison on May 20 relating to intern and residency programs in this state. The Commission on Hospital Relations and Medical Education is concerned that insufficient numbers of graduates from the two medical schools in Wisconsin take internship and residency training in their state of education, and even more with the difficulty of the 20 institutions approved for residency training in maintaining an adequate program in that field. This is a matter of particular concern in Wisconsin and should command the joint interest not only of the Society, but of the two medical schools, hospitals, and other interested parties.

From time to time there needs to be a refocusing of attention to problems of particular concern to the medical profession generally as well as in Wisconsin. The Council has felt that generally speaking, the attention of the membership in Wisconsin has been directed primarily within recent years to problems within the state to the exclusion, almost, of problems more national in scope.

In July, Doctor Blasingame, Executive Vice President of the American Medical Association, met with the Council to paint with a "broad brush" his views of national problems and of activities of the AMA.

Early in 1961 the Council approved the constitution of a special committee of physicians to go to Washington, not alone to confer with the Wisconsin Congressional delegation, but also with appointive officers and private agencies in other fields. A five-day schedule of interviews was developed along this line, but the scope of the studies undertaken during the trip and as a result of it is sufficiently broad as to suggest the advisability of a special report at a later date.

This report is not intended to be repetitious and will be supplemented by a special report by the Chairman of the Council at the time of the House meeting.

SUPPLEMENTARY REPORT OF THE COUNCIL, MAY 1, 1961

The Council met in two sessions on Sunday, April 30, and makes the following supplementary report:

1. Personal Service Corporations

The membership has received the annotated bill to permit physicians and other self-employed professionals the same privilege of tax-deferred income programs as is accorded the corporation employee. The Council has recorded its approval of this bill and I would urge all physicians to support it and enlist the aid of other self-employed individuals in seeking its passage.

2. Health Assistance to the Aged

Every member of the Society has received a copy of the proposed bill to implement the Kerr-Mills Act in Wisconsin. The social significance of this legislation cannot be over-emphasized. The development of the Kerr-Mills Act was strongly supported by the American Medical Association and its implementation in Wisconsin is a challenge to medicine to demonstrate its concern for a sound and dignified program of health care for the needy aged who encounter unusual health care expense.

The Council recommends the bill for House approval and further recommends that the Society seek an amendment to the bill specifically stating a guarantee of free choice of physician for its beneficiaries.

3. Supplementary Report of Division on Handicapped Children

This House of Delegates in May 1960 requested revision of the Bicillin program operated through the State Bureau of Handicapped Children to eliminate mandatory confirmation by a specialist or heart clinic of the physician's original diagnosis of rheumatic fever.

The Division on Handicapped Children of the Commission on State Departments has worked with the state bureau in establishing a new program based on the Jones criteria. This report is forwarded to the House with Council approval. (See page 425 of this issue.)

4. Public Policy Resolutions

The Council discussed two matters of special concern to the Commission on Public Policy with its chairman, Doctor Quisling

Chiropody in Wisconsin is seeking changes in its statutory definition. The Commission finds agreement with certain portions of the chiropody proposals, but substantial difference exists as to others. The problem is not limited by state boundaries and accordingly the Council recommends approval of the resolution attached to the Report of the Commission on Public Policy (see page 406 of this issue) requesting our delegates to the American Medical Association to seek a thorough study of chiropody on a national basis.

The Commission also expressed to the Council its growing concern with chiropractic use of the title "doctor" and its misleading representations to the public. The Council approves the second resolution attached to the Report of the Commission on Public Policy (see page 405 of this issue).

5. Resolution on Social Security Health Care

The Council believes that the Society should reaffirm its opposition to Forand-type legislation as embodied in several bills in the 87th Congress. It therefore transmits to the House a resolution expressing opposition to social security health care of the aged, commending those who have similarly opposed such programs, and urging endorsement and support of the American Medical Association's ten-point program on aging.

Resolution on Social Security Health Care

WHEREAS, The 87th Congress is considering several new versions of bills designed to establish a compulsory health tax program for the elderly; and

WHEREAS, The members of the State Medical Society believe such measures to be a type of socialized medicine and the forerunner of a national compulsory health tax system for the entire population; and

WHEREAS, The individual would suffer both as citizen and patient under such legislation; and

WHEREAS, Such legislation would compel the patient to accept government benefit regardless of need or desire, reduce his free choice of physician and handicap the personal relationship with his physician; and

WHEREAS, The patient would find his course of treatment controlled as much by bureaucratic regulation as by his condition; and

WHEREAS, Wisconsin physicians through their own contributions to the care of the needy aged and in cooperation with local and state voluntary official programs have made it possible for virtually every person, regardless of age, to receive the health care he requires; and

WHEREAS, A National compulsory health tax scheme for one age group will ultimately lead to the extension of political medicine to other groups and thus hinder efforts to improve the care of all the people; therefore be it

Resolved, That the House of Delegates of the State Medical Society of Wisconsin commend those members of Congress and all others who have opposed with determination and vigor this trend toward a socialistic program of national compulsory political medicine; and be it further

Resolved, That the State Medical Society of Wisconsin endorse and support activities to implement the American Medical Association's ten point program on aging throughout the State of Wisconsin; and be it further

Resolved, That copies of this resolution be sent to the President of the United States, John F. Kennedy; the Vice-President of the United States, Lyndon B. Johnson; Speaker of the House of Representatives, Sam Rayburn; Members of the House ways and Means Committee:

Wilbur D. Mills
Thomas J. O'Brien
Frank M. Karsten
Frank Ikard
James B. Frazier, Jr.
John C. Watts
James A. Burke
John W. Byrnes
Thomas B. Curtis
James B. Utt
Bruce Alger
Cecil R. King
Hale Boggs
A. S. Herlong, Jr.
Thaddeus M. Machrowicz
William J. Green, Jr.
Al Ullman
Noah M. Mason
Howard H. Baker
Victor A. Knox
Jackson E. Betts
Steven B. Derounian;

Members of the Senate Finance Committee:

Harry Flood Byrd
Russell B. Long
Clinton P. Anderson
Albert Gore
J. W. Fullbright
Frank Carlson
John Marshall Butler
Thruston B. Morton
Eugene J. McCarthy
Robert S. Kerr
George A. Smathers
Paul H. Douglas
Herman E. Talmadge
John J. Williams
Wallace F. Bennett
Carl T. Curtis
Vance Hartke;

Secretary of Health, Education and Welfare Abraham Ribicoff; The Wisconsin Congressional Representatives:

Alexander Wiley
Rev. Henry C. Schadeberg
Vernon W. Thomson
Henry S. Reuss
Melvin R. Laird
Lester R. Johnson
William Proxmire
Robert W. Kastenmeier
Clement J. Zablocki
William K. Van Pelt
John W. Byrnes
Alvin E. O'Konski;

Governor of the State of Wisconsin, Gaylord A. Nelson; Members of the Wisconsin Legislature, Trustees of the American Medical Association and all members of the State Medical Society of Wisconsin.

6. County Medical Society Speaking Programs

The Council heard many suggestions as to how medicine might best express its position to the public in Wisconsin. It was felt that the respect with which physicians are regarded in their own communities affords them an opportunity to become more active in bringing medicine's views to the people of this state. The following resolution is presented to the House:

Resolved, That the Council of the State Medical Society of Wisconsin recommend to this House of Delegates that each county medical society designate certain members of its local society to prepare and present to local groups in their own communities medicine's views and stands on state and national issues relating to medicine and health.

7. Financial Report

The last session of the House of Delegates approved a recommendation of the Reference committee on Reports of Officers that delegates be provided with a report on the financial condition of the State Medical Society and its related activities. Such a report is transmitted for your information.

Financial and Operating Data on the Society and Its Related Activities

April 25, 1961

To the Council of the State Medical Society of Wisconsin

Gentlemen:

Attached is a tabulation showing Financial Condition and Income and Expenditures of the State Medical Society of Wisconsin and its related activities. With the exception of information for the Charitable, Educational and Scientific Foundation, financial condition is shown as of December 31, 1960 and income and expenditures are shown for the twelve months ended December 31, 1960. Information on the Foundation was supplied to us by the Society's Accounting Department, and shows financial condition at March 31, 1961 and income and expenditures for the nine months ended March 31, 1961. The Foundation's fiscal year ends June 30, 1961. We have audited records of the Foundation at June 30, 1960.

All of the information shown, with the exception of that for the Foundation as noted above, is taken from our audit reports for the year ended December 31, 1960. Certain footnotes and contingent liabilities which are a part of statements in these audit reports are incorporated in this report by reference. As you know, detailed information on each of these activities is presented to, and reviewed by, appropriate committees or boards of the Society.

State Medical Society of Wisconsin
Madison, Wisconsin

Financial and Operating Data on the Society and its Related Activities
For Dates and Periods Indicated

Financial Condition	At December 31, 1960							At March 31, 1961
	S.M.S. Gen. Fund	W.M.J.	W.P.S.	Medicare	W.V.M.S.A.	S.M.S. Realty Corp.	Pension Plan	Foundation
ASSETS								
Current	$ 94 777 89	$25 118 51	$3 495 234 55	$117 765 62	$	$ 87 665 74	$99 892 33	$ 96 143 17
Fixed (Net)	29 352 60	298 81	499 652 01	10 00		390 101 51		139 496 33
Other	18 568 31	2 169 02	23 531 62			3 909 87		15 341 94
TOTAL	$142 698 80	$27 586 34	$4 018 418 18	$117 775 62	$	$481 677 12	$99 892 33	$250 981 44
LIABILITIES, RESERVES AND CAPITAL								
Current	$ 23 776 08	$ 9 882 92	$1 455 613 86	$ 57 775 62	$	$ 19 878 89	$	$ 38 238 25
Fixed		17 703 42		60 000 00		277 500 00		
Deferred Income	23 435 00		1 108 146 13					
TOTAL LIABILITIES	$ 47 211 08	$27 586 34	$2 563 759 99	$117 775 62	$	$297 378 89	$	$ 38 238 25
Reserves and Special Capital			1 454 658 19			41 249 47	99 892 33	212 743 19
Current Surplus and Donated Capital	95 487 72					143 048 76		
TOTAL	$142 698 80	$27 586 34	$4 018 418 18	$117 775 62	$	$481 677 12	$99 892 33	$250 981 44

Income and Expenditures	Twelve Months Ended December 31, 1960							Nine Months Ended March 31, 1961
	S.M.S. Gen. Fund	W.M.J.	W.P.S.	Medicare	W.V.M.S.A.	S.M.S. Realty Corp.	Pension Plan	Foundation
INCOME								
Dues	$246 898 50	$	$	$	$	$	$	$
Premiums			9 164 209 36					
Other	32 682 87	75 283 48	82 822 94	24 302 92	614 40	127 456 11	3 964 25	33 360 58
TOTAL	$279 581 37	$75 283 48	$9 247 032 30	$ 24 302 92	$ 614 40	$127 456 11	$ 3 964 25	$ 33 360 58
EXPENDITURES								
Benefits	$	$	$7 990 930 30	$	$	$	$	$
Administration	276 537 84	68 562 22	1 107 594 42	24 302 92	614 40	114 497 57		17 131 01
TOTAL	$276 537 84	$68 562 22	$9 098 524 72	$ 24 302 92	$ 614 40	$114 497 57	$	$ 17 131 01
Excess-Income Over Expense	$ 3 043 53	$ 6 721 26	$ 148 507 58	$	$	$ 12 958 54	$ 3 964 25	$ 16 229 57
Appreciation in Market Values of U.S. Govt.Securities Held			114 639 08					
TOTAL	$ 3 043 53	$ 6 721 26	$ 263 146 66	$	$	$ 12 958 54	$ 3 964 25	$ 16 229 57

NOTES: 1. Inter-activity receivables and payables included above in assets and liabilities, and itemized in individual audit reports, are not eliminated from these statements.

2. Employer and employee contributions to the Pension Plan, totaling in 1960 $23,874.92, are treated, not as income, but as additions to principal of the plan.

This information is supplied to you in accordance with a recommendation of the Reference Committee on Reports of Officers to the 1960 session of the House of Delegates, duly adopted.

Respectfully submitted,

DONALD E. GILL & COMPANY
Certified Public Accountants

8. Announcements

I am pleased to announce several actions of interest to physicians, hospitals and others.

The Council has reappointed Dr. T. W. Tormey, Jr., Madison, as general chairman of the Commission on State Departments.

It has appointed Dr. John Evrard of Milwaukee to fill a vacancy created by the resignation of Dr. George Kilkenny who has served as chairman of the Division on Maternal and Child Welfare for five years.

The Council reappointed the other division chairmen, as follows:

A. M. Hutter, M.D., Fond du Lac, Division on Aging
H. A. Anderson, M.D., Stevens Point, Division on Chest Diseases
J. W. Nellen, M.D., Green Bay, Division on Handicapped Children
E. D. Schwade, M.D., Milwaukee, Division on Nervous and Mental Diseases
H. W. Carey, M.D., Lancaster, Division on Public Assistance
Ray Piaskoski, M.D., Milwaukee, Division on Rehabilitation
Dayton Hinke, M.D., Richland Center, Division on Safe Transportation
L. M. Simonson, M.D., Sheboygan, Division on School Health
Meyer S. Fox, M.D., Milwaukee, Division on Visual and Hearing Defects

For the second consecutive year the Council, upon the recommendation of the Commission on Hospital Relations and Medical Education, has presented hospital awards to two hospitals which exemplify a fine relationship between medicine, hospital administration, and boards of trustees in the provision of high quality health care. The recipients of the awards to be presented next week during National Hospital Week are St. Joseph's Memorial Hospital, Hillsboro, and St. Luke's Memorial Hospital, Racine.

The Charitable, Educational and Scientific Foundation is permitted 10 non-medical trustees, on election by the Council, in addition to approximately 80 physician trustees. Originally only two non-medical trustees were appointed—The Honorable Oscar Rennebohm of Madison, and A. Matt Werner of Sheboygan.

I am pleased to announce the selection of three additional non-medical trustees—Warren E. Clark, Milwaukee, agent for Northwestern Mutual Life Insurance Company; E. E. Bryant, Stoughton, president of the Nelson Muffler Corporation; and Robert B. L. Murphy, Madison, attorney and currently president of the State Historical Society. I am sure these men can bring a great deal of wise counsel to the activities of the Foundation.

9. Report on Washington Trip

A special committee of seven physicians was appointed by the Council to go to Washington to survey the socio-political-economic scene. It conducted interviews with about 50 Congressmen, representatives of executive departments, and private agencies. Its report and recommendations follow.

REPORT OF SPECIAL COMMITTEE OF THE COUNCIL

of the

State Medical Society of Wisconsin

WASHINGTON, D. C. TRIP

March 13–19, 1961

Recommendations

Medicine in its responsibilities to a world of progress must exercise a new leadership devoted not so much to scientific technology as to the art and skills of social survival. This is what, in the jargon of Washingtonese, is called "assuming a new posture."

In the last 100 years American medicine, and Wisconsin for its part, has assumed undisputed leadership in the scientific aspects of health care. The accomplishments for the cure and alleviation of disease and injury are nothing short of miraculous when viewed in their entirety. Medical education has risen from the level of incompetency to the heights of world superiority in quality. In more recent decades medicine has opened the door to significant advances in the development of economic mechanisms to assist the patient in meeting the cost of unexpected illness or injury.

But there is still a largely untouched area of socio-economic activity into which the medical profession must move with rapidity and decisiveness lest its apathy be mistaken for disinterest and unconcern. This is the area sometimes described as the profession's interest in good citizenship. Others call it the coordination of existing health resources and still others explain it as an area of enlightened cooperation between the patient and the physician.

Medicine has created a wide spectrum of specialties in the interest of providing the highest quality medical service by the finest trained physicians. Yet the public remains confused as to how best to utilize the skills of this medical excellency.

Voluntary health insurance brought on one of the most spectacular economic advances in modern history. Yet thousands upon thousands of our citizens find payment for health service a complex and confusing business. The financing of a $3,000 automobile is regularly undertaken without hesitation, yet a $500 hospital-surgical-medical bill is frequently regarded as a catastrophe for which there "ought to be a law."

Medicine has developed within its own structure highly responsive grievance mechanisms for the protection of the public and physician alike. Yet complaints are not uncommon that there is no adequate means for seeking justice on matters relating to the cost or quality of health services.

An astonishing array of special diagnostic and treatment services are available to the average citizen, yet he knows little of how to obtain these services for himself and his family. A wide variety of facilities both short term and long term, general and specialized, are available for his care. But he, the citizen, finds it difficult to know which is best for his use.

Added to the confusion is the constant din of those who cry for more government regulation and control, those who wish a bureaucratic government to assume complete jurisdiction of the health care of the American people.

This is the "New Frontier" for the medical profession. In the long view it is the response that medicine gives to this challenge that will determine its ability to survive the clamor for bureaucratic government control of health and medical care.

It is in this light that the special committee of the Council makes the following recommendations as a consequence of its trip to Washington.

1. KERR-MILLS LEGISLATION

The most immediate task confronting all of medicine and more specifically the State Medical Society of Wisconsin and those who hold a similar hope for preservation of free medical practice is the implementation of Kerr-Mills legislation. The 86th Congress gave medicine and its allies an opportunity to develop added assurance for those over 65 that unusual health care expenses need not deprive them of dignity or security in their declining years. There are many who drag their feet and there are many who discourage the use of the Kerr-Mills mechanism —they prefer complete government control and operation of the care of the aged as a stepping stone to a national compulsory health insurance system. But there are equally numerous and vigorous pleas for rapid and effective implementation of Kerr-Mills legislation. The committee urges the Society to pursue its Kerr-Mills proposals and to enlist the widest possible support for its passage in Wisconsin.

2. DEFEAT OF H.R. 4222 AND S. 909 AND SIMILAR LEGISLATION TO ACHIEVE COMPULSORY HEALTH INSURANCE

Simultaneously with implementation of Kerr-Mills legislation in Wisconsin is the necessity for broad front attack on legislative attempts to initiate a national compulsory health insurance scheme in this country. To accomplish this the committee recommends:

A. Immediate implementation of the American Medical Association's "Medical Aid for the Aging" program, to inform the public through every channel of communication available to it. The American Medical Association has developed an effective and comprehensive program for the defeat of these federal legislative proposals. The State Medical Society and every county medical society must stand four-square behind the American Medical Association in this program.

B. The Committee on Health Economics in American Life of the State Medical Society, formerly identified as the Federal Legislative Committee, should initiate at once a strong educational and informational program with regard to Kerr-Mills and federal legislation. It is suggested that the committee undertake a Health Care-A-Van tour of the entire state to bring a team of qualified speakers into each area, to enlist support from those who are interested and to explain medicine's position to the public.

C. The AMA News constitutes one of the most factual and concise presentations of medicine's position on socio-economic matters. It is recommended that the Society send complimentary subscriptions of the AMA News to a non-medical mailing list of approximately 1,000 to 1,500 persons in Wisconsin.

The committee is convinced, from the response of Congressmen and others visited on its recent trip to Washington, that continuing direct contacts in the Nation's Capital are an essential contribution by the profession of Wisconsin to preservation of sound legislative action in the health and medical care field. Such trips, while undertaken periodically in the past, should be established with changing personnel on a regular and continuing basis.

3. VOLUNTARY HEALTH INSURANCE

The efforts of the medical profession and other purveyors of voluntary health insurance continue to be the major socio-economic tool to assist the public in meeting the expenses of health care. The Society must maintain its leadership by providing new and better mechanisms to meet the public's needs in this regard. Increased emphasis is recommended particularly in the provision of deductible type and major illness coverages for groups and individuals in all age categories.

4. MEDICAL SOCIAL SERVICE

Medicine has made outstanding progress in developing a wide range of preventive, therapeutic and restorative services through an equally wide variety of facilities involving growing numbers and types of health personnel. The committee is firmly convinced that these accomplishments have given rise to an unusual opportunity for improving the accessibility of services and improvement of medicine's relationship to the public. What is most needed is a medically oriented, medically directed service to patients, wherever they may be, to assist them in their efforts to obtain the best medical care, to arrange the easiest possible mechanisms for payment, to overcome some of the social, cultural and even psychological barriers which sometimes stand between the patient and physician, to help the patient utilize personnel and resources in the most economically and yet most effective fashion, and to serve as a recognized center for reliable information and assistance in obtaining medical care and solving related health problems. Too often today the only source of information and aid is from an organization or individual whose sympathies do not lie with medicine. Left in a vacuum or encouraged by those with a social welfare philosophy the patient is giving evidence of turning to government for advice and information he should properly receive from medicine itself.

The committee therefore recommends that the Society immediately undertake a study of the means for establishing a medically sponsored social service program to supply the people of Wisconsin with acceptable and reliable information on how to obtain the highest quality medical care with the greatest ease and at the most reasonable cost and to assist with their personal problems related to receiving health care.

5. PUBLIC INFORMATION

Medicine's accomplishments in the provision of quality medical care and the protection of public health are a story too seldom appreciated and more frequently unrelated to the basic economic and social principles which made America great. The committee urges the Society to give greater attention to relating these accomplishments in the proper socio-economic setting to the people of Wisconsin. First and foremost, among these efforts is the establishment of an aggressive, vigorous speakers bureau . . . manned by informed, articulate physicians and non-medical friends in other professions and organizations. These speakers should be scheduled for television, radio and organizational appearances.

There is no question but what television and radio are potent media of communications. The Society should give priority in the public information field to greater utilization of both . . . and if necessary for financial reasons, in concert with other organizations sharing mutual aims.

6. PUBLIC HEALTH

The committee observed what appears to be a whittling away of the responsibility traditionally placed under public health leadership in government. There

is concern lest public health be absorbed in a broader, less specific governmental program whose direction would lean toward absolute bureaucratic government control.

Sound public health programs, medically based, are vital to the nation's health and well-being. The committee feels that the Society should take the leadership in Wisconsin by providing every encouragement for the preservation of public health functions in the State Board of Health and the placing of new governmental responsibility affecting health and medical care in the hands of those trained in public health. It, therefore, urges the Society to undertake in cooperation with the State Board of Health an extensive survey of current public health responsibilities and activities as well as new areas of public health activity which might lead to more unified direction of public health in Wisconsin and more vigorous, effective public health service to the people of this state.

REPORT OF COMMISSION ON PUBLIC POLICY

1960–1961

A. A. QUISLING, M.D.
Chairman

A. A. Quisling, M.D., Madison, *Chairman*
R. G. Zach, M.D., Monroe
J. M. Sullivan, M.D., Milwaukee
E. C. Quackenbush, M.D., Hartford
D. N. Goldstein, M.D., Kenosha
Norbert Enzer, M.D., Milwaukee
L. J. Kurten, M.D., Racine
E. D. Sorenson, M.D., Elkhorn, ex officio
L. H. Lokvam, M.D., Kenosha, ex officio

Medicine is not infrequently the object of noisy criticism for allegedly being "against everything" on the legislative scene. Those who voice such sentiments are simply not aware of the facts, or they have designs on discreditation in one form or another. Never has this been better illustrated than in this session of the Wisconsin Legislature.

There are already more than 1,000 bills and resolutions before the State Legislature. No less than 120 of these are in some measure of concern to the State Medical Society because of their implication upon some aspect of public health or because of direct effect upon the practice of medicine and the treatment of the sick. Obviously, if medicine is to meet a responsibility to its own traditions and to the public, it must make a stand on many issues. To be *against* quackery is to be *for* public health. To be *for* seat belts in automobiles is to be *against* needless injury and death. To be *for* improved public health organization is to be *against* epidemic and disease. The test that the medical profession places on every issue must be, as it always has been, that which is best for the health of the people of Wisconsin.

There is no need to outline each of the bills which has drawn the attention of this Committee. Through regular communications we have attempted to inform the membership and the public policy contacts in each county on those bills of significance. We shall continue to do so.

It is important, however, to emphasize certain legislation which requires special understanding and effort.

The first in this category is the Kerr-Mills legislation. In the Senate this is embodied in Bill 466, S. In the Assembly, an identical bill is numbered 550, A. The entire membership has received the details of this legislation by mail.

This bill seeks to implement the Kerr-Mills Act in Wisconsin. It has potential for affecting about 175,000 elderly Wisconsin citizens by enabling them to maintain their self-respect while receiving health care assistance on a basis other than indigency. Neither the magnitude nor the significance of this program can be underestimated. American medicine has taken a leading role in offering this mechanism to relieve certain of the needy aged. Wisconsin medicine supports this approach, and it now becomes our responsibility to rally the legislature and others to create in this legislation an effective instrument of public health.

Next, your attention is directed to the bill, introduced with the support of the Medical Society, for the purpose of permitting physicians and certain other self-employed to establish retirement plans and defer the tax on income so allocated until the time that its benefits are received. The entire membership has received copies of the substitute amendment to this bill which will shortly be offered in the legislature. Let it be emphasized again, that this bill proposes only to bring tax equality to certain of the professions . . . physicians, dentists, attorneys and CPA's among others. The employees of corporations already have this privilege. Many other self-employed already have the opportunity. In this bill the professions request only what they deserve . . . equal treatment. The bill can become a reality if the professions and others affected will push it.

The Society is also deeply interested in several bills relating to the practice of chiropody, or what perhaps is more appropriate, "podiatry." The podiatrist performs a useful and needed service. The essential question is the scope of his practice. This hinges, as it does with all scientifically sound adjuncts to medicine, on the quality and scope of education. The Committee on Public Policy has learned that podiatry, nationally, is currently undertaking its own evaluation of its schools. The Committee believes that the close relationship of the podiatrist and the physician requires an evaluation of the entire matter in its broadest public health concept.

In quite a different context, the Committee wishes to focus attention on another area of the treatment of the sick . . . the cult of chiropractic. The intensity with which this cult seeks to achieve legislative recognition belies the validity of its basic premise as a healing art or science. Public acceptance of its precepts would appear to hinge more on its success in the use of publicity than on understanding of its merit. It is time, long overdue, that medicine go to the people with the facts concerning this cult and the limitations wisely placed by the legislature upon its practice in Wisconsin. Your Committee, therefore, recommends the adoption of the attached resolution relative to chiropractic.

In conclusion, then, the Committee on Public Policy appeals to the leadership of our profession, and to the membership of our Society, for the vigorous exercise of its responsibility as a profession to provide strong guidance to those who make our public health laws. This is a duty extending beyond that of the

A Resolution Relating To Chiropractors In Wisconsin

WHEREAS, The unrestricted use of the title "Doctor" in health care is a privilege reserved by the Legislature for those who have attained certain high standards of comprehensive education, learning and competence in the care and treatment of the whole human being; and

WHEREAS, There is widespread willfull misuse of the title "Doctor," in clear and flagrant violation of Wisconsin statutes, by many limited licensees and others who treat or assist in the treatment of the sick; and

WHEREAS, The Wisconsin Supreme Court, in an opinion confirming the prohibition against the use of the title "Doctor" by chiropractors, declared: "The title does not aid him in the treatment, it merely aids him in securing the confidence of prospective patients and in inducing people to apply for treatment;" and

WHEREAS, Continued violation of the legislative intent to protect the public health weakens the public's confidence in the Legislature and the title "Doctor," confuses the public in the selection of competent health care, decreases respect for the law and sound, scientific health practice; therefore be it

Resolved, That the State Medical Society of Wisconsin make a strong appeal to the Wisconsin Legislature and state and local law enforcement offices for immediate and full enforcement of the statutes with regard to the proper use of the title "Doctor" by all who treat the sick; and be it further

Resolved, That the State Medical Society of Wisconsin, in the interests of providing sound health guidance for the citizens of this state, challenge the improper use of the title "Doctor" wherever it occurs by publicly exposing such misleading and dangerous practices; and be it further

Resolved, That this House of Delegates of the State Medical Society of Wisconsin authorize the preparation of a statement, in manner approved by the Council, which contains the official definition of "chiropractic" and the limitations upon its practitioners in that the law of Wisconsin denies them:

The right to use the title "doctor"
The right to sign vital statistics records including death certificates
The right to use electrotherapy
Any privilege under the quarantine laws
Treatment of the workmen's compensation case
Treatment of public assistance cases
The use of drugs and medicines in the rendition of chiropractic treatment
The use of electrocoagulation procedures
The right to puncture the skin or take blood samples
The right to suggest or advise a course of diet or corrective dietary habits
The right to render psychosomatic counselling to patients
The right to make a medical diagnosis
The use of such instruments as colonic irrigators, diathermy, plasmatic, short wave, radionics, or ultrasonic;

and be it finally

Resolved, That such statement be circulated to all law enforcement officers of this state, educators and others to the end that the public be educated as to the strict limitations upon these practitioners and not be misled as to their qualifications as the result of a vast amount of erroneous information being distributed by them.

physician as a citizen. The special knowledge of the physician must be clearly imparted to the lawmaker if he is to act in the most intelligent and enlightened fashion on matters of health care.

This responsibility is much like the obligation that every physician feels toward the provision of security for his family. He would not think of failing to provide, within his means, the greatest possible measure of protection for his family through life, fire, auto, disability, liability and other types of insurance. The very least that every physician can do in protection of public health and the quality of medical care is a modest expenditure of time, money and attention for the affairs of government. Anything less is an irresponsibility and neglect that ill befits the professional man.

A RESOLUTION

The laws of the various states are not uniform in their definition of chiropody and its scope of practice. This becomes a matter of public health interest, particularly since "Hospital Accreditation References," a publication of the Joint Commission on Accreditation of Hospitals and the American Hospital Association, 1959, states:

"A hospital staff may vote a chiropodist privileges in his specialty. Each hospital staff must evaluate the chiropodist who applies for hospital privileges and set up qualifications, rules and regulations.

"Chiropodists must be under the jurisdiction of the department of surgery. A physician must be in attendance when the chiropodist is operating in the hospital on an inpatient. Where minor outpatient podiatry is performed, it will be done under the supervision of the surgical department although actual attendance is not required. The chiropodist is in the nature of a technician, functioning under the surveillance and supervision of a physician.

"The Chiropodist is not qualified to write the history or physical examination nor check the heart and lungs before an anesthetic. This applies also to prescribing drugs both preoperatively and postoperatively in the hospital.

"The podiatric patient must be admitted to the hospital under the physician's name. The chiropodist cannot and does not have the privilege of admitting a patient under his own name.

"It is in no way obligatory that a chiropodist be given privileges. It is up to each individual hospital staff to evaluate the hospital's needs, the individual's qualifications and competence, and then vote on the matter with recommendations to its board of trustees. The board of trustees of any hospital, before giving approval to such election, should make sure that the hospital's bylaws, rules and regulations spell out all facts and privileges."

Resolved, That this House of Delegates request its delegates to the American Medical Association to seek a thorough review and study of chiropody by the AMA for the purpose of establishing agreement as to its definition, the scope and quality of its education, and uniformity as to its standards of practice; and be it further

Resolved, That this resolution be transmitted promptly to the AMA Board of Trustees and to its Executive Vice President with a request for early implementation.

REPORT OF COMMITTEE ON DISASTER MEDICAL CARE

1960–1961

E. P. LUDWIG, M.D.
Chairman

E. P. Ludwig, M.D., Wausau, *Chairman*
J. S. Wier, M.D., Fond du Lac
E. A. Bachhuber, M.D., Milwaukee
S. J. Graiewski, M.D., Oshkosh
D. L. Williams, M.D., Madison
Harold Cook, M. D., Milwaukee

Wisconsin's plans for dealing with Disaster Medical Care occasioned by either military or natural causes are entering a new phase — training of personnel.

Substantial progress has already been made in the appointment of county medical directors, the location of 200-bed emergency hospitals, the establishment of mobile medical teams and the acquisition and placement of emergency medical care supplies.

Now the emphasis swings to training.

The Committee has worked closely with the health services section of the state civil defense organization. It assisted in the development of the recently revised and approved mobile medical team manual with special emphasis on emergency treatment of disaster casualties. As a means of establishing uniformity of understanding and application of emergency treatment of disaster casualties, the committee wrote into the new manual the AMA's recommendations on this subject.

The committee also approved publication of a "Lesson Plan—Instruction of Non-Medical Personnel in Emergency Medical Care (20 hour training program)." This training guide will be distributed only to medical personnel and civil defense authorities and will be a major training aid for mobile medical teams and hospital disaster personnel.

Both of these publications are due to be distributed by early summer of 1961.

In another phase of the training of civil defense personnel, physicians should be alerted to the fact that the district nurses associations of the Wisconsin State Nursing Association are conducting a series of 20 hour courses over a period of ten weeks. Physicians will be asked to assist in presenting these training sessions on emergency medical care.

Of special interest to physicians is the medical and paramedical immunity protection afforded them under Wisconsin civil defense laws passed by the 1959 session of the Wisconsin legislature. Interpretation of these laws makes it clear that physicians are afforded Workmen's Compensation coverage and tort liability protection when they are duly registered in writing with a bona-fide civil defense unit. Such protection applies whenever they are engaged in authorized training or emergency activities. A full report on the interpretation of this protection will be published in the Wisconsin Medical Journal.

The Committee on Disaster Medical Care is pleased to note the appointment of William Chipman, Madison, as the new Director of Civil Defense for the State of Wisconsin. The Committee extends to him a sincere welcome and offers the cooperation and assistance of the State Medical Society of Wisconsin in the development and operation of an adequate and effective program of disaster medical care.

REPORT OF COMMITTEE ON CANCER

1960–1961

P. M. CUNNINGHAM, M.D.
Chairman

PAUL M. CUNNINGHAM, M.D., Appleton, *Chairman*
J. W. BOREN, JR., M.D., Marinette
C. W. STOOPS, M.D., Madison
A. H. STAHMER, M.D., Wausau
R. C. FRANK, M.D., Eau Claire
G. I. UHRICH, M.D., La Crosse
R. C. GLISE, M.D., Richland Center
G. A. SMILEY, M.D., Delavan
J. J. GRAMLING, JR., M.D., Milwaukee
J. F. BROWN, M.D., Rhinelander
J. R. HOON, M.D., Sheboygan
R. P. WELBOURNE, M.D., Watertown
R. R. MATACZYNSKI, M.D., Superior

Summary

The Committee on Cancer has initiated a Cancer Coordinating Committee in cooperation with thirteen other agencies, both voluntary and public, which have a direct interest in the detection and control of cancer. It will be the purpose of this Coordinating Committee to review the cancer programs of all participating organizations so as to observe the over-all intent and effect of these programs and to make policy suggestions concerning greater coordination of all activities, improve liaison between all groups, and serve as a study and research advisory group for major problems in cancer detection and control.

During the past year the Committee has urged the Wisconsin Division of the American Cancer Society to place greater emphasis on colostomy care training among nurses in Wisconsin, increase the availability of speakers on colostomy care and to provide more information to patients, the medical profession and allied groups. It has also urged the Division to continue its smoking-cancer educational program at the high school level.

The Committee also proposes to study means of extending the American Cancer Society's smoking-cancer educational program to the profession as a means of reaching high school students.

Cancer is now the second leading cause of death in Wisconsin. This is true for three primary reasons:

1. The number of deaths from other major causes such as tuberculosis and pneumonia has been reduced.
2. The population is aging and cancer occurs more frequently among older people, and
3. Physicians are using modern medical facilities to find cases that previously have gone undetected.

Although the most dangerous period for development of cancer is after middle age, it is a leading cause of death throughout life.

Cancer is the second leading cause of death in the age bracket 5 through 64 years. At 65 and over cancer becomes the third ranking cause of death with diseases of the heart and vascular lesions affecting the central nervous system ranking first and second. In the age group 1 to 4 years, cancer is the fourth ranking cause of death headed only by accidents, influenza and pneumonia and congenital malformations.

Cancer deaths and death rates skyrocket after age 40. Early cancer case finding is important at any age but it should be given particular emphasis during the critical age period from 40 to 60.

These are a few of the facts reported in a recent publication entitled "Cancer in Wisconsin" published by the Wisconsin State Board of Health. This over-all view of cancer as a major health problem in Wisconsin is one of the reasons for the establishment, through the State Medical Society Committee on Cancer, of a Cancer Coordinating Committee involving the Wisconsin Division of the American Cancer Society, the Milwaukee Division of the American Cancer Society, State Board of Health, Wisconsin Academy of General Practice, Wisconsin Surgical Society, Wisconsin Society of Pathologists, Wisconsin Society of Internal Medicine, Wisconsin Society of Obstetrics and Gynecology, Wisconsin Radiological Society, Wisconsin State Dental Society, Wisconsin State Nurses Association, University of Wisconsin Medical School and Marquette University School of Medicine.

The initial meeting of the Cancer Coordinating Committee was held on January 28, 1961. At that time it was agreed that the Coordinating Committee would serve the following purposes:

A. Review the cancer programs of all participating organizations so as to observe the over-all intent and effect of these programs and to make policy suggestions concerning greater coordination of all activity.
B. Improve liaison between the participating groups.
C. Prevent, to the greatest extent possible, unnecessary duplication and overlapping in the programs undertaken by the participating groups.
D. Suggest and advise the participating groups on means to bring "action" to their program.
E. Serve as a study and research advisory unit for major problems of cancer detection and control.

It has been agreed that the Coordinating Committee will be non-operational in nature. Its actions will be of an advisory nature at the policy level involving voluntary coordination by the participating agencies.

The next meeting of the Coordinating Committee is scheduled for late May at which each participating organization will present a summary of its program activities in all fields of cancer. Thus, the Committee will establish a basis for review and ultimate coordination of cancer activity in the state.

The Committee on Cancer wishes to remind Wisconsin physicians that its members serve in a dual capacity as members of the State Medical Society's Committee on Cancer and as members of the Medical and Scientific Committee of the Wisconsin Division of the American Cancer Society.

In this capacity the Committee regularly meets with the Board of Directors of the Wisconsin Division. The Committee has during the past year urged the Wisconsin Division to:

A. Sponsor programs on colostomy care for nursing schools, surgical nurses, hospital personnel, visiting nurse associations and public health nurses.
B. Increase the number of speakers available to talk to groups of all types on the subject of colostomy care.
C. Expand the availability of information for all groups on colostomy care.

D. Secure a film on colostomy care, since it appears that no professional film is currently available on this subject.
E. Continue the smoking-cancer educational program at the high school level.

Working with the Wisconsin Division of the American Cancer Society, the Committee on Cancer has also indicated that it will study means of expanding the smoking-cancer program of the American Cancer Society to the medical profession in Wisconsin as a means of reaching young people of high school age.

REPORT OF COMMITTEE ON MILITARY MEDICAL SERVICE

1960–1961

F. L. WESTON, M.D.
Chairman

F. L. Weston, M.D., Madison, *Chairman*
J. M. Sullivan, M.D., Milwaukee
M. H. Steen, M.D., Oshkosh
O. G. Moland, M.D., Augusta
D. S. Arvold, M.D., Shawano

After several years on a standby basis, the Committee on Military Medical Service has been reactivated in response to requests from the Wisconsin Selective Service System for advice on the availability of physicians for a "draft."

A call for physicians has been issued involving approximately 250 physicians nationwide, with an allocation of perhaps five of these to Wisconsin. The call is necessitated by the failure of a sufficient number of physicians completing their internship to volunteer for duty in the several reserve programs of the Armed Forces.

It would appear that the Selective Service call will affect physicians born January 1, 1931 or later, and the necessary physicians will be called on the basis of the youngest first.

Recent contacts with the Department of Defense indicate that physicians may fulfill their military obligation (without subjecting themselves to "draft") by service in reserve units such as the general hospital units in Milwaukee and Madison and medical units of the Wisconsin National Guard.

There are several exceptions to this:

In emergency conditions, where requirements of the active Army cannot be satisfied from reserve officers in control groups.
If the officer fails to meet the satisfactory participation requirements of attending drills.
If the officer has been or is deferred under the Berry Plan and the active Army needs his particular specialty at the time he ends his residency and deferment.
If the officer is subject to active duty as a result of completing the advance course ROTC.
If the officer is commissioned after being ordered to active duty.

Physicians who are liable for involuntary active duty may therefore avail themselves of this opportunity by applying to a reserve or national guard hospital unit with a position vacancy. If accepted they will be commissioned and assigned to the unit.

Upon reaching age 35 these officers may resign their commission without incurring further obligation.

REPORT OF COMMITTEE ON CLINICAL MEDICINE

1960–1961

T. J. GREENWALT, M.D.
Chairman

T. J. Greenwalt, M.D., Milwaukee, *Chairman*
Karl H. Beck, M.D., Wauwatosa
Maurice Hardgrove, M.D., Milwaukee
N. A. McGreane, M.D., Darlington
Albert W. Bryan, M.D., Madison

Summary

The Committee on Clinical Medicine, created by action of the Council on May 1, 1960, makes the following recommendations:

1. Every county medical society in Wisconsin is urged to give the widest possible promotion to the use of polio vaccine in the spring of 1961 as a safeguard against epidemic.
2. A survey be undertaken of Wisconsin blood bank services to determine their ability to provide blood as needed by physicians for the care of their patients.
3. Development by the American Medical Association of literature, films and other materials to promote tetanus immunization for the adult. The Committee has been unable to determine that such materials are available at the present time.

The Committee is seeking to implement Resolution C adopted by the House of Delegates of the State Medical Society in May, 1960. This resolution urged the Society's support in the development of summer camp programs for diabetic children.

* * *

The State Medical Society's "Immunization Guide," as prepared by the Division on School Health of the Commission on State Departments, has been reviewed by the Committee on Clinical Medicine. It is suggested that the latest information concerning the "four-in-one" DPTP vaccine be included in future publications of the guide.

Considerable concern has been expressed over the failure of adults to obtain immunization protection against tetanus. Although several county medical societies in the state have undertaken extensive public educational programs against tetanus, there is an obvious need for widespread public understanding of the need for immunization against this condition. Efforts to obtain useful literature for patient education have proved unsuccessful. The Committee therefore recommends that the American Medical Association develop appropriate literature for this purpose and make it available throughout the nation in an effort to combat tetanus and the costs

and disability attendant upon emergency anti-tetanus measures.

Resolution C of the House of Delegates of May, 1960, requested the State Medical Society's support for the development of summer camp programs for diabetic children and is being implemented by the Committee. Inquiries are being made of those who sponsor camp programs for girls in the western and north central part of Wisconsin to ascertain whether they will accept as many as 15 to 20 diabetic girls. Should such a camp or camps be willing to cooperate, services of one or more physicians must be arranged on a daily basis to supervise the diabetic control program for these youngsters. The Wisconsin Diabetes Association will provide a full time nutritionist-dietician and registered nurse for such camps provided they cooperate in the program. The Association will also provide financial assistance to youngsters who are unable to pay the cost of staying at such camps. The major need is for camps which will accept girls since adequate facilities are already available in Wisconsin for diabetic boys.

The Committee strongly recommends that every county medical society promote, to the widest possible extent, the use of polio vaccine in the spring of 1961 as a safeguard against epidemic. The Committee urges that each society undertake to give the utmost in support to the American Medical Association anti-polio program as outlined in the attached release.

A.M.A. JOINS BIG POLIO DRIVE; TARGET: LOW INCOME GROUPS

CHICAGO—With 40 per cent of the nation's population not yet inoculated against polio, the American Medical Association announced today that it is taking the leadership again this year with the U. S. Public Health Service and the National Foundation in an all-out drive to stimulate state and county medical societies throughout the country in a spring polio campaign.

"Polio still remains a serious health menace," said Dr. Julian P. Price, Florence, S. C., chairman of the A.M.A. Board of Trustes, "and state and county medical societies will be urged to cooperate with the U.S. Public Health Service and the National Foundation in getting more people to take their polio shots."

The A.M.A., the Public Health Service, and the National Foundation are cooperating at the national level in the drive, dubbed the "Babies and Breadwinners" campaign for 1961.

Dr. Price said the campaign will be aimed primarily at the younger age groups in the lower economic area and is designed to stimulate all-out effort by the local organizations.

Dr. Price announced that the Advertising Council of New York again is volunteering its services in launching the 1961 polio campaign in April. "Timing of the campaign is important," Dr. Price said, "in order that everyone can receive at least three polio shots before the summer polio season."

He said that success of the campaign depends on joint activity at the local level. The local campaigns, sponsored by medical societies, boards of health, and voluntary health agencies, will be tied in with the nationwide campaign.

The A.M.A. leader assured all sponsoring groups of receiving wholehearted cooperation from the more than 2,000 state and county medical societies throughout the country.

"Contrary to recent reports," Dr. Price said, "the A.M.A. is strongly behind every effort to encourage the public to take advantage of the Salk vaccine without delay. This is the official policy of the A.M.A. as enunciated in a resolution adopted by the A.M.A. House of Delegates at a meeting in Washington, D.C., last December."

He pointed out that this year's campaign is an extension of similar drives led by the A.M.A. the last three years in an effort to persuade every unvaccinated person to protect himself, his family, and his neighbors with Salk vaccine shots.

Dr. Price said that 38 per cent of all children five years old and younger have not yet been inoculated against polio. In addition, 63 per cent of men, aged 20–40, and 48 per cent of the women in this age group have not been inoculated. A high proportion of this group is from low income areas.

"These are segments of the population never reached by previous polio appeals and they should be the special targets in the 1961 polio campaign. As long as 'islands of unvaccinated persons' exist even within well-vaccinated communities, polio epidemics remain a serious threat. Consequently, the campaign should be directed primarily toward low income groups not normally reached by private physicians in their offices or even by special polio clinics."

Goals and priorities for the '61 program follow:

1. Every person should be fully immunized against polio.
2. Immunization campaigns should be intensive in neighborhoods with less than 85 per cent vaccination in groups under age 6, where epidemics are most likely to occur.
3. The first priority groups to receive "complete and early coverage" should be infant and preschool groups under 8 years of age. Other children under 10 and parents of young children comprise the second priority group.

Dr. Price urged that all community-sponsored polio immunization programs be planned and carried out in close cooperation with local medical societies. He said that the schedule of Salk vaccine shots will remain about the same—the second shot to be given one month after the first, the third, seven months after the second or before the next polio season, and the fourth one year later. This applies to all persons except infants under 6 months.

REPORT OF COMMITTEE ON GRIEVANCES

1960–1961

E. J. NORDBY, M.D.
Chairman

E. J. NORDBY, M.D., Madison, *Chairman*
H. J. BELSON, M.D., Manitowoc
R. R. RICHARDS, M.D., Eau Claire
E. D. SORENSON, M.D., Elkhorn
E. W. MASON, M.D., Milwaukee
R. W. MASON, M.D., Marshfield
R. E. FITZGERALD, M.D., Milwaukee
K. A. MORRIS, M.D., Merrill
J. D. LEAHY, M.D., Park Falls

Cases Reviewed and County Society Cooperation

This Committee has reviewed a number of situations involving physicians during the past twelve months. These included several over which county societies had primary jurisdiction but sought and received advice and assistance from the State Society. On many which were originally referred to the State Society, this Committee received valuable information, advice and aid from county societies.

The Committee wishes to commend the county societies both for their cooperation with the State Society and for their independent handling of numerous grievances arising in their own areas.

Eliminating the Grievance at Its Source

Last year's report set forth certain of its impressions derived from experience in reviewing complaints. It also offered suggestions on preventing the causes from which a majority of complaints originate. The Committee's more recent experience has reconfirmed both its impressions and its belief in the validity of its suggestions.

The Committee urges physicians to re-read its 1960 report as printed in the *Wisconsin Medical Journal* for July, 1960, and to consider carefully the suggestions therein made. Reprints are available on request.

Conference with Bar Representatives

This Committee recently has had a conference with representatives of the State Bar of Wisconsin on problems of mutual concern to the medical and legal professions. It has noted that many of such problems could quickly be resolved by applying principles contained in the Interprofessional Code jointly sponsored by the State Medical Society and the State Bar. See *Wisconsin Medical Journal* for January, 1960.

The Committee urges physicians to re-read the Interprofessional Code and, in appropriate situations, to suggest tactfully that attorneys refer to its principles. Members may replace lost copies of the code by request addressed to the State Medical Society.

H. Kent Tenney, M. D., and the March of Medicine

This Committee's primary concern is with the impartial review and fair disposition of grievances brought to its attention. But it is not unmindful of its secondary duty to protect the reputations of physicians, individually and collectively, against the threat of harm contained in nearly every complaint. What the Committee can do in fulfillment of this secondary duty is limited by the fact that the unfortunate incident from which a grievance arises always occurs and frequently does its damage before it becomes subject to Committee review.

Accordingly, outstanding service on behalf of medicine's reputation must be sought and found elsewhere. The good name of medicine has a solid basis because the vast majority of individual physicians faithfully observe the principles of medical ethics, but it has force only to the extent that its meaning is vividly realized in the public mind. This Committee believes that one of the finest achievements in bringing that meaning home to the public in Wisconsin has been Dr. H. Kent Tenney's work on the air waves with the MARCH OF MEDICINE.

The Committee congratulates Doctor Tenney on his contribution to this program.

REPORT OF COMMITTEE ON HEALTH ECONOMICS OF AMERICAN LIFE

1960–1961

R. N. ALLIN, M.D.
Chairman

R. N. ALLIN, M.D., Madison, *Chairman*
G. C. SCHULTE, M.D., Kenosha
L. J. KURTEN, M.D., Racine
MILLARD TUFTS, M.D., Milwaukee
NORBERT ENZER, M.D., Milwaukee
E. A. STRAKOSCH, M.D., Oshkosh
J. R. HEERSMA, M.D., Marshfield
GEORGE NADEAU, M.D., Green Bay
C. A. OLSON, M.D., Baldwin
M. L. WHALEN, M.D., Bruce
J. W. MCGILL, M.D., Superior
A. J. MCCAREY, M.D., Green Bay
S. J. GRAIEWSKI, M.D., Oshkosh

Your chairman was privileged to accompany a special committee of the Council of the State Medical Society on a seven-day trip to Washington, D. C. and Chicago during March for the purpose of evaluating the socio-political-economic scene as it affects medicine and public health. This series of interviews with Congressmen, Senators, executive department heads and other representatives of federal agencies was most enlightening, and the recommendations of the special committee are reported separately. However, several impressions are pertinent specifically to the responsibilities of the Committee on Health Economics of American Life:

The Secretary of Health, Education and Welfare told us:

> "If you are not satisfied with my proposal for Social Security health care of the aged, you should see your Wisconsin Congressmen."

One veteran Congressman said:

> "This kind of visit is most important. You should do it more often."

Another Congressman said:

> "You can help us a great deal by keeping in close touch and by making sure that your specific reasons for support or opposition to these bills . . . with examples . . . get to us in writing."

Still another Congressman said:

"We have given the states an opportunity (Kerr-Mills Act) to show how they can deal with the problems of the needy aged. I can't impress upon you the urgency of early implementation of this Act in Wisconsin."

Another said:

"Expand your program to reach the public with your story. Tell the story of your accomplishments for better health in this country."

Everywhere there were discussions, pro and con, concerning the King-Anderson proposals of the Administration for care of the aged under Social Security. There was concern for early implementation of the Kerr-Mills Act in Wisconsin. It was obvious that the efforts to push through the Forand-type Social Security proposals continue unabated. Let no physician think the pressure is off. Senator Kerr, speaking before the AMA Legislative Conference said:

"The night that you and your friends go to sleep is the night it will happen."

The trip to Washington made clear the chilling truth of this statement.

But neither let any physician think the situation is hopeless. Far from it. In fact, our own worst enemies are apathy, ignorance and pessimism.

There is widespread recognition by the public and by many Congressmen that the Social Security approach to health care of the aged is fiscally too burdensome, too drastic a remedy, too dangerous a social measure. Medicine has substantial support in its position . . . and there is every reason to believe that the Social Security approach to this problem need not be enacted . . . IF

1. Physicians understand the problem and the facts.
2. The facts and medicine's position can be communicated more effectively to the public and to Congress.
3. The Kerr-Mills Act is implemented effectively in Wisconsin.

American medicine has a vigorous, effective program to assure high quality medical care for the nation's citizens, of all ages. The American Medical Association has provided leadership for a nationwide program of public information and education on the issues. The State Medical Society of Wisconsin and its members are part of that plan. We must do our part.

This Committee is prepared to assist all members and the county medical societies in these responsibilities. We can provide guidance . . . we can provide stimulation . . . we can, through the AMA and the State Medical Society offices, provide special materials, literature, films, facts and figures, brochures, tape recordings, radio and TV scripts and spot announcements, recordings for women's groups, and advertising copy for newspapers . . . we can urge you to write your Congressman and to inform your patients, local officials and others.

But only you . . . the delegates, the county society officers, the membership at large . . . can do this job where it counts . . . in your home town.

The chairman and members of this Committee are ready and willing to address your county medical society. We will, within the limits of our capacity, speak to non-medical groups.

Speakers' kits and promotional kits are being sent to the secretary of every county medical society. They will be sent to other physicians upon request. A speakers' bureau is being established.

Do not hesitate to act. Do not wait. There is no time to let someone else do it.

Kerr-Mills legislation needs your support in Wisconsin. You voice, and the voices of your friends, must be heard in Washington in opposition to the King-Anderson proposals for Social Security care of the aged.

This committee is broadly charged with concern for many matters relating to the national socio-economic scene. Among these is evaluation of federal legislation, analysis of national socio-economic trends affecting medicine and public health, and programs of support or opposition to legislation of current standing in Congress.

It is reported that more than 5,000 bills have already been introduced in this session of the 87th Congress. More are coming every day. The American Medical Association is currently considering its position on more than 100 of these bills. The AMA Board of Trustees meets this month to establish policy with regard to most of these.

This committee wishes to direct attention to a few of special significance on which the AMA position is already established:

H.R. 4222 — By Congressman King — providing payment for hospital, skilled nursing home and home health care services to aged beneficiaries under the OASDI program. . . . AMA opposed.

S. 909—By Senator Anderson—companion Senate bill to H.R. 4222, the King proposal. There are twelve other similar measures in both houses, all calling for Social Security health care of the aged . . . AMA opposes.

H.R. 1341—By Congressman Roberts—requiring passenger carrying motor vehicles purchased by the federal government to meet certain safety standards . . . AMA supports.

S. 1072—By Senator Hill and others—providing
a. matching grants for construction, replacement or rehabilitation of medical schools.
b. scholarships and related grants to partially meet the cost of instruction at medical schools, and extension and expansion of the research facilities construction program.

. . . AMA supports the portion relating to matching grants for construction, but has not yet taken a position on the other portions of the bill. AMA is now establishing a $200,000 annual scholarship program and a multi-million dollar loan program for medical students.

Mental Health—AMA recently testified before the Senate Committee on Judiciary on plans to develop legislation dealing with the prevention and management of mental illness and the rights of the mentally ill. AMA supports in principle. Specific bills may be introduced later.

H.R. 10—encourages the establishment of voluntary pension plans by self-employed individuals —AMA supports.

H.R. 1937—By Congressman Griffiths, and

H.R. 3556—By Congressman Moulder—setting up federal controls for the care of experimental animals . . . AMA opposes these anti-vivesectionist supported bills believing proper care can better be achieved locally and without undue restriction on medical education and research.

REPORT OF THE TREASURER

Year Ended December 31, 1960

F. L. WESTON, M.D.
Treasurer

To the House of Delegates:

In accordance with Section 3, Chapter 5 of the Bylaws of our Society, I submit to you my annual report.

As in previous years I am reporting to you here only on those funds which are the direct responsibility of the Treasurer, designated as the Society's "General Fund". Information on financial condition and income and expenditures of related activities of the Society is submitted to you separately, in accordance with a recommendation made to you last year by the Reference Committee on Reports of Officers, which you adopted.

The following Exhibits and Schedules make up this report:

Exhibit A—Financial Statement at December 31, 1960
Schedule A-1—Reconciliation of Net Worth at December 31, 1960
Exhibit B—Statement of Income and Expense—Year Ended December 31, 1960

The records of the State Medical Society of Wisconsin have been audited for the year 1960 by Donald E. Gill & Company, Certified Public Accountants.

F. L. WESTON, M.D.
Treasurer

Exhibit A

STATE MEDICAL SOCIETY OF WISCONSIN GENERAL FUND
Madison, Wisconsin

FINANCIAL STATEMENT
December 31, 1960

ASSETS		
Cash	$40,853.35	
Accounts Receivable	1,627.66	
Due From Society Divisions—Current	35,131.73	
Due From Related Organizations—Current	16,740.15	
Guaranty Deposit	425.00	
Working Capital Advance—Wisconsin Medical Journal	17,703.42	
Furniture and Equipment—Cost Less Depreciation	11,649.18	
Prepaid Expenses and Deferred Charges	18,568.31	
TOTAL ASSETS		$142,698.80
LIABILITIES		
Accounts Payable	$ 6,672.58	
Due Officers and Employees	1,002.93	
Dues—Suspense	347.50	
Accrued Property and Payroll Taxes	15,103.61	
Accrued Expense	649.46	
Prepaid Membership Dues	9,050.00	
Other Prepaid Income	14,385.00	
TOTAL LIABILITIES		47,211.08
NET WORTH		
Surplus—General Fund	$77,107.26	
Net Worth of Wisconsin Medical Journal	17,703.42	
Surplus Reserved for Section on Medical History	677.04	
TOTAL NET WORTH		$ 95,487.72

Schedule A-1

STATE MEDICAL SOCIETY OF WISCONSIN GENERAL FUND
Madison, Wisconsin

RECONCILIATION OF NET WORTH
Year Ended December 31, 1960

Net Worth—December 31, 1959	$ 92,722.93
Additions	
Excess of General Fund Income Over Expenses—1960	3,043.53
Total	$ 95,766.46
Deductions	
Reduction in Working Capital Advance—Wisconsin Medical Journal	278.74
Net Worth—December 31, 1960	$ 95,487.72

Exhibit B

STATE MEDICAL SOCIETY OF WISCONSIN GENERAL FUND
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1960

INCOME		
Membership Dues	$246,368.50	
Dues—Section on Medical History	530.00	
Annual Meeting	26,728.50	
Teaching Clinics	2,094.00	
Administrative Services	2,731.38	
Miscellaneous Income	824.67	
Gain on Disposal of Fixed Assets	304.32	
TOTAL INCOME		$279,581.37
EXPENSES		
Auditing and Accounting Consultation Services	$ 3,984.04	
Conference Expense	33,831.97	
Depreciation	3,034.10	
Legal Services	6,580.84	
Legislative Retainer	9,499.99	
Office Supplies	4,813.21	
Outside Services	10,643.82	
Payroll	119,619.10	
Payroll Taxes and Employee Benefits	12,007.01	
Postage and Express	9,271.02	
Printing and Forms	14,237.67	
Rent—Central Office	21,130.00	
Rent—Other	6,431.59	
Telephone and Telegraph	3,234.57	
Travel Expense—Staff	8,600.34	
Other Expenses	16,105.68	
Total	$283,024.95	
Less: Portions of Above Expenses Charged Out for Services Rendered to Others	6,487.11	
TOTAL EXPENSES		276,537.84
EXCESS—INCOME OVER EXPENSE		$ 3,043.53

REPORT OF COMMISSION ON SCIENTIFIC MEDICINE

1960–1961

M. C. F. LINDERT, M.D.
Chairman

M. C. F. LINDERT, M.D., Milwaukee, *Chairman*
R. B. LARSEN, M.D., Wausau
R. W. FARNSWORTH, M.D., Janesville
A. R. CURRERI, M.D., Madison
P. T. BLAND, M.D., Westby
R. S. BALDWIN, M.D., Marshfield
JOHN Z. BOWERS, M.D., Madison
JOHN S. HIRSCHBOECK, M.D., Milwaukee

During the past year the former Council on Scientific Work sought to clarify its responsibilities within the structure of the State Medical Society and associated scientific activities conducted under the direction of the Charitable, Educational and Scientific Foundation.

The Council has authorized the Council on Scientific Work to change its designation to the "Commission on Scientific Medicine" and to assume responsibility for scientific and educational programs conducted under the sponsorship of the Foundation as well as similar activities directly associated with Society affairs.

Coordinated Efforts

With the advent of specialization, and similar cohesiveness within the ranks of those physicians who do not devote their time to a single specialty there has been a tendency within the Society to concentrate attention on scientific programs within a narrow field of medical practice, or to associate oneself in terms of postgraduate medical education with a certain membership structure within the framework of the over-all State Society membership. This has been particularly true in the area of general practice, wherein the Academy on both a national and state level has developed a strong and commendable teaching program, supported in large part through grants of pharmaceutical houses. These teaching programs, plus associated programs at the two medical schools, and various scientific programs conducted by specialty societies all suggest the need for close coordination to assure the best possible success to each program, and to avoid duplication of program scheduling so far as possible. The Commission on Scientific Medicine is attempting to do this, and in the years ahead, it is hoped that more of the special interest groups within the Society will seek the assistance of the Commission in both the development of programs and their presentation.

The Annual Meeting

As a means of making the Annual Meeting of greatest benefit to the greatest number of members, the Commission has been pleased to offer several new programs this year: one in gastroenterology, one in orthopedic surgery, and an associated program in allergy incorporated as part of the program in Internal Medicine. In addition, this year, the two medical schools have been asked to present special programs on the first morning of the Annual Meeting, to outline some of the newer and most significant work being done by their faculty members.

Illustrating to what extent the Commission on Scientific Medicine can assist with associated teaching programs special attention is directed to the Tuesday evening "Fireside Conferences," which have been developed cooperatively with the Wisconsin Chapter of the College of Chest Physicians. Instead of presenting these teaching sessions independently, the Chest Physicians have incorporated them as an integral part of the Annual Meeting program as a service to the many physicians who will be in attendance at that time.

Closer Cooperation with Specialty Groups

The Commission is pleased to report that an increasing number of specialty groups are working closely with the Commission to provide teaching material to members of the State Society through organized functions of the Society itself. The Wisconsin Society of Pathologists and the Wisconsin Society of Allergists have sought the assistance of the Commission in making available to the State Society the teaching services of their members, through both the Speakers Service and the Circuit Teaching Programs. It is hoped that as time goes on more of the specialty groups will coordinate their efforts in this manner.

Speakers Service to County Societies

For the past two years the Commission has organized and promoted a Speakers Service for County Medical Societies, cooperatively with the financial support of the Wisconsin State Board of Health, the Wisconsin Heart Association, W.A.T.A., and the Wisconsin Division of the American Cancer Society. This academic year additional support has been accorded the program by the Postgraduate Teaching Program of Merck Sharp & Dohme Company in Philadelphia.

Many societies have availed themselves to this service, and it has provided a means of reimbursing speakers in an orderly manner, without cost to the individual County Society served. Since September 1960 through January 1961 (when this report was drafted) the following counties have been served by this program:

	Number of Speaking Engagements
Barron-Washburn-Sawyer-Burnett	2
GreenLake-Waushara	3
Jefferson	4
La Crosse	1
Marathon	1
Outagamie	1
Ozaukee	5
Polk	1
Price-Taylor	1
Portage	3
Racine	1
Richland	4
Rock	4
Sauk	3
Washington	2
Waukesha	1
Winnebago	2
5th Councilor District	1 (3 speakers)
9th Councilor District	1
	41

Below is a general division of the amounts contributed for the number of talks sponsored by each of the cooperating agencies:

Sponsoring Agency	Number Filled	Amount Contributed	
		Paid Speakers	Admin. Expenses
Charitable, Educational and Scientific Foundation	3	$ 133.01	$
American Cancer Society	1	45.00	6.00
Wisconsin Heart Association	3	105.00	18.00
State Board of Health	7	255.00	
Wisconsin Anti-Tuberculosis Association	1	35.00	6.00
Merck Sharp and Dohme Co.	25	985.00	150.00
	40	$1,558.01	$180.00

It is anticipated that a number of additional speakers engagements will be filled as a part of this program, between February and June of this year.

Because of financial support accorded the program as indicated the cost of this service to the State Medical Society has been very small. To what extent grants for this program can be continued beyond this academic year is of course a matter of conjecture, but the program is one of such value to the smaller county societies served that the Com-

mission strongly urges its continuance, and ample provision made in the budget of the Foundation to continue it in the future.

Financial Statement of the Speakers Service for 7/1/60–1/31/61 (not audited).

Cash on Hand (7/1/60)	$4,098.22	
Income		
Merck Sharp & Dohme Company (incl. $150 administrative)	1,135.00	
American Cancer Society (incl. $6.00 administrative)	51.00	
Wisconsin Heart Association (incl. $18.00 administrative)	123.00	
Wisconsin Anti-Tuberculosis Assoc. (incl. $6.00 administrative)	41.00	$5,448.22
Expenses (paid out to speakers)		
Merck Sharp & Dohme Company	$ 985.00	
American Cancer Society	45.00	
Wisconsin Heart Association	105.00	
Wisconsin Anti-Tuberculosis Assoc.	35.00	
Charitable Foundation	133.01	$1,303.01
Balance		$4,145.21

Circuit Teaching Programs

For approximately the past 20 years, the State Society has assisted in the education of its members by presenting brief regional programs of a diversified character, as a means of keeping the busy practitioner alert to new developments in the care of patients, without the necessity of his leaving his practice for more than a single day. These programs, first termed "Spring Clinics" and later as "Circuit Teaching Programs" have met a real need, and even though attendance has lessened during the past decade, they are of distinct value and should be continued.

Primarily the Circuit Teaching Programs are presented for the benefit of the generalist. During the past several years an accelerated program of postgraduate education under the immediate direction of the Wisconsin Academy of General Practice has provided many generalists with teaching which heretofore had been available only through the Circuit Teaching Programs of the State Society. The "Series 16" programs of the Academy are providing teaching for many of the Academy members in the larger communities, such as Madison, Kenosha, Janesville, Eau Claire, Wausau and Superior.

To avoid the competition with these programs of the Wisconsin Academy, the Commission on Scientific Medicine proposes to conduct a series of afternoon programs, each in a series of two consecutive meetings, in the smaller communities of Wisconsin during the next academic year. Faculty members from the two medical schools in Wisconsin will be utilized in the main, though an occasional visiting professor from Chicago or Minnesota may be included in a few of the Circuits. Tentative plans call for meetings in these sites:

Sept. 13—Marinette–Menominee, Michigan
Sept. 14—Waupaca
Oct. 3—Ashland or Superior
Oct. 4—Rhinelander or Antigo
Oct. 28—New Richmond or Chippewa Falls
Oct. 29—Rice Lake
Nov. 1—Platteville or Lancaster
Nov. 2—Richland Center

Second Series (If Money Available)

Jan.—Viroqua
Jan.—Wisconsin Dells
Jan.—Beaver Dam
Jan.—West Bend
Feb.—Elkhorn or Fort Atkinson
Feb.—Watertown or Oconomowoc
Mar.—Berlin
Mar.—Wisconsin Rapids

To what extent this full schedule can be completed depends in part on the financial support accorded the program. If supporting funds can be secured from the Postgraduate Teaching Program of Merck Sharp & Dohme, the entire schedule will be followed; if not, meetings from September through November will be presented this year, and programs presented in the other sites during the Fall of 1963.

Special Conferences

While major attention of the Commission has been directed to the Annual Meeting and the Circuit Teaching Programs, it hopes in the ensuing years to stimulate and present special state-wide conferences in areas of medical practice of special concern to the profession at large. The initial attempt will be that of presenting a state conference on "Medical Aspects of Mental Retardation," through the Charitable, Educational and Scientific Foundation and in cooperation with the Divisions on Nervous and Mental Diseases and Maternal and Child Welfare, a number of related state agencies, and the Wisconsin Association for Mental Health. The Conference will receive its basic support in a grant from the Wisconsin Council for Mentally Retarded Children. It is anticipated that this program will coordinate the efforts of many interested lay groups as well as the physicians of the state, and that it will direct public attention to the work of the State Society.

It is anticipated that in ensuing years other types of conferences might be developed which will associate the work of voluntary health agencies with the scientific affairs of the State Society.

Scientific Aspects of the Journal

The Commission is privileged to work in close cooperation with the Medical Editor and the Editorial Board of the *Wisconsin Medical Journal* on scientific aspects of the Society's official publication. The Journal is recognized as one of the leading state medical publications in the country, and part of the success of the Journal is the care in which the scientific articles are secured and edited. As a means of lightening the load on the Medical Editor and increasing the capacity of the Editorial Board, the Council authorized the position of Assistant Medical Editor, and filled this position with the appointment of Victor S. Falk, M.D., Edgerton. The State Society owes a debt of gratitude to the Medical Editors and the Editorial Board for their excellent service to medicine and the physicians of Wisconsin.

* * *

The Commission on Scientific Medicine is anxious to serve all elements within the State Society in the furtherance of scientific knowledge and the development of strong and practical teaching programs. It is felt by Commission members that much can be accomplished through cooperative effort, and the Commission holds itself in readiness to coordinate the work of all groups within the Society, in terms of scientific advancement and medical knowledge.

REPORT OF COMMISSION ON PUBLIC RELATIONS AND COMMUNICATIONS

1960–1961

D. M. WILLISON, M.D.
Chairman

D. M. Willison, M. D., Eau Claire, *Chairman*
J. S. Devitt, M.D., Milwaukee
W. J. Fencil, M.D., Monroe
C. J. Picard, M.D., Superior
David G. MacMillan, M.D., Barron
W. E. Acheson, M.D., Valders
D. E. Dorchester, M.D., Sturgeon Bay
J. E. Martin, Jr., M.D., Delevan
G. M. Shinners, M.D., Green Bay

Activities of this Commission fall largely into three major categories . . . public information, rural health and industrial health. Frequently, of course, these are closely inter-related and become indistinguishable as part of the broad area of public relations.

However, the Commission wishes to report the continued fine reception of its public information efforts by the media of communication, and most importantly, by the public. The radio "fans" of the March of Medicine continue to grow under the direction of H. Kent Tenney, M.D. In addition, a high percentage of the radio stations in Wisconsin also utilize the AMA's radio recording series entitled "Medical Milestones."

Through news releases, brochures, literature, speaker's aids, loan packets, films and other public relations aids, the Society provides Wisconsin medicine with a substantial program of public information on medicine, public health and health education.

Latest in a series of health education aids for those in rural Wisconsin is a brochure on "Family Health Preservation." This guide to healthier living is to be distributed in 1961 to thousands of 4-H club leaders and members and county home agents and homemakers. It will deal with such subjects as selecting a personal physician and dentist, the need for periodic physical examinations, an immunization schedule, keeping health records, and the use of iodized salt, fluoridated water, first aid and an understanding of health insurance.

Simultaneously, the Commission has been studying the expanded use of television for telling the medical story. Currently a video-tape film is in production to test the possibilities of this mechanism for a new type of "March of Medicine" program. At the same time the Commission encourages county medical societies which have local television stations in their areas to work directly with these stations in the development of appropriate public information programs. The Commission and the Society staff are available for consultation and advice.

The Commission wishes to direct the attention of each county medical society to a forthcoming publication of the American Medical Association which is designed to provide guidance and helpful advice in the establishment of local PR programs.

The Committee on Occupational Health is making plans for an Occupational Health Clinic to be held in the fall of 1961 in Madison. Still under study by the Committee is a guide to "Work and the Heart" in relation to industry.

Several members of the Commission serve in a liaison capacity with the Wisconsin State Medical Assistants Society on a continuing basis. The Commission recommends that all physicians encourage their medical assistants to become active in this group. Such participation not only improves the medical assistants capacity, but is an important part of medicine's community relations program.

REPORT OF COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION

1960–1961

R. S. GEARHART, M.D.
Chairman

R. S. Gearhart, M.D., Madison, *Chairman*
C. J. Picard, M.D., Superior
G. E. Collentine, Jr., M.D., Milwaukee
J. P. McCann, M.D., La Crosse
T. H. McDonell, M.D., Waukesha
M. V. Overman, M.D., Neillsville
S. L. Henke, M.D., Eau Claire
T. E. Boston, M.D., Hillsboro
H. G. Bayley, M.D., Beaver Dam
John Z. Bowers, M.D., Madison, ex officio
John S. Hirschboeck, M.D., Milwaukee, ex officio

Special liaison concerning Chapter 484
R. C. Frank, M.D., Eau Claire
R. S. Haukohl, M.D., Milwaukee
T. W. Tormey, Jr., M.D., Madison

Chapter 484

The letter circulated to all members of the State Medical Society on November 25, along with the "Guide to Interpretation of Chapter 484" (Bill 129, A.) began with these words:

"This Guide to the Fee Splitting Statute is of deep professional and personal concern to every physician in Wisconsin."

The import of these few words cannot be overemphasized. Indeed, they may not yet be fully appreciated.

This Guide, in its concern for the legal, ethical, professional and economic relations of physicians to hospitals and certain areas of service reaffirms certain longstanding legal and moral principles and sets forth several new approaches to problems which have developed because of changing times.

It must be remembered that the new law is in part simply a reaffirmation of the old fee splitting statute which had been enacted in 1913. What is new in it relates primarily to the relationships of physicians, medical staffs and hospitals with special emphasis on the continuing responsibility for both medical staff and hospital to review any arrangements which may have been in existence on January 1, 1961, or which may be newly entered into on any later date.

There is full recognition of the fact that precise answers are not available in advance for every question relating to the application of this law. Thus, the Commission on Hospital Relations and

Medical Education has moved with great deliberation, both in preparation of the Guide and in dealing with questions which have been raised subsequent to its distribution.

The Commission and its Executive Committee have held a total of six lengthy meetings since the last session of the House of Delegates. The Guide was presented in complete detail to the Council, prior to adoption by it.

Every question concerning the application of the law to specific situations has been reviewed by the Commission or its Executive Committee before advice has been given. For the time being, at least until broad guide lines of interpretation are clear to both it and the Council, this policy will be followed.

While a major portion of the implementation of the law deals with legal interpretations as to the relationships between physician and hospitals, and between physicians, it is evident that ethical considerations are inevitably interwoven. These are matters for Council deliberation, and as such, they will be brought to the Council's attention.

In this regard, close liaison between the Council and the Commission is invaluable, and the presence of Councilor Frank in this capacity with the Commission is deeply and sincerely appreciated.

The Need for Medical Students

During the past few months, the Commission has been impressed with the obvious necessity for urgent and vigorous action to deal with the growing shortage of qualified applicants for medical school. The long-range consequences of this lag should concern every physician, and even more, every citizen.

A few facts will serve to pin-point the problem:

1. Wisconsin has about 104 physicians per 100,000 of population; the United States as a whole has about 135.
2. With respect to the ratio of applicants for medical school to population, Wisconsin ranks 44th in the nation.
3. The annual rate of newly licensed physicians is low for Wisconsin, 2.8 per 100,000 as compared with 4.6 for the United States.
4. Wisconsin ranks 25th among the 50 states in the number of active non-federal physicians in relation to population. The rate is 98 per 100,000 as compared with the national average of 118 per 100,000.
5. More than half of Wisconsin medical school graduates move to practices outside Wisconsin. Although in previous years this was offset by the fact that about 50 per cent of physicians practicing in Wisconsin graduated from schools outside the state, since 1954 this number has decreased to about 33 per cent.
6. In order to raise the ratio of physicians to population up to the national average, in order to replace physicians who retire or die and in order to provide for an increasing population, an average of about 240 new physicians will be needed each year for the next 15 or 20 years, but the current number being added each year is only about 135.

Another aspect of the problem is highlighted with these facts:

1. Over 99% of all medical students work some or all of the time while in medical school. Deans recommend no more than 10 hours per week of outside work . . . yet 10% of medical students work 40 hours per week or more, the average student works 15 hours weekly.
2. If funds were available, the average medical student reports he would borrow at least $4,000 in additional funds during four years of education.
3. The median amount of loans received by medical students during four years of schooling is $2,555.
4. The average cost of four years of medical education is $11,642 . . . about $9,800 for single students, up to $16,000 for married students.
5. The average student gets 82% of his resources from family loans or gifts plus his own or wife's earnings from employment. About 18% of his funds come from outside scholarships and loans.
6. Only 14% of medical student graduates come from families earning $5,000 or less annually . . . 43% come from families with over $10,000 annual income . . . thus, a major method of increasing the number of physicians is to broaden the socio-economic base from which they are drawn.
7. Increasing financial aid is available to Wisconsin medical students through the Charitable, Educational and Scientific Foundation of the State Medical Society. While many applications are still pending for lack of funds, the Foundation already has nearly $80,000 out on loan at the present time. Through funds such as those in the Foundation, medical students can normally be assured of sufficient financial aid to complete studies once begun.

There is general agreement in the Commission that dwindling interest in the field of medicine has almost reached the crisis stage. If this be true, immediate steps should be undertaken to remedy it. With this in mind, the Commission, through an ad hoc committee on medical education, has already initiated the following activities:

1. A pilot program of medical student recruitment has been started in three areas of the state. Its purpose is to provide intensive contact with high school students through interviews, addresses to school convocations, personal physician relationships, medical student contact, news media and guidance counselling. If this proves successful, it will be expanded to all county medical societies.
2. Teachers and guidance counselors are being made aware of the critical shortage of qualified applicants to medical schools through communications from the office of the State Department of Public Instruction and the Wisconsin Educational Association.
3. The March of Medicine radio program of the State Medical Society is being utilized to bring an important message on this topic to 53 Wisconsin radio stations with an estimated listening audience of 500,000. Tape recordings of this program are also being made available to high schools for use in guidance classes, and other classes in an effort to dispel some of the "myths about medical education."
4. In cooperation with the Society's Commission on Public Relations and Communications, an extensive health careers brochure is being prepared for widespread distribution throughout the state to young people interested in medicine and related careers. Primary emphasis will be placed on the needs in the medical field. A considerable variety of audio-visual aids for recruitment is also available to any interested person or group.

The Commission recommends approval of these activities and support from all county medical societies and individual physicians in seeking to interest

a substantial number of men and women in medicine as a career.

In addition, the Commission has under consideration a number of other proposals designed to assist in this recruiting effort. As these plans are developed, approval will be sought from the Council.

Medical Education

The Commission is also equally deeply concerned with another and related problem in medical education: the postgraduate medical educational opportunities in Wisconsin hospitals and the impact of this phase of medical education upon the ability of Wisconsin to attract physicians for practice in this state. Specifically, the inability of most Wisconsin hospitals to attract sufficient numbers of medical graduates to fill approved internship program quotas is becoming a problem of considerable proportion.

Again, the presentation of certain facts will illustrate the situation:

1. For internship year July 1, 1960–June 30, 1961, there were 12,381 internships to be filled in the United States through the National Intern Matching plan. There were 6,672 students matched in the plan. Unfilled internships thus totaled 5,709.
2. In Wisconsin during this period, 21 hospitals sought 229 interns. The plan matched 74 interns to these vacancies for a 32.3% result.
3. In addition to the number of interns matched to hospitals offering intern programs, additional vacancies were filled from unmatched students, non-participants, and graduates of foreign medical schools. No final record of the numbers of intern vacancies after additional appointments by hospitals are made is available.

Below is listed the 1960 results of the plan:

	Interns[1]	
	Sought	Matched
Eau Claire		
Luther Hospital	6	1
Fond du Lac		
St. Agnes Hospital	6	0
Janesville		
Mercy Hospital	5	0
La Crosse		
La Crosse Lutheran Hospital	6	0
St. Francis Hospital	8	0
Madison		
Madison General	14	6
Methodist Hospital	5	0
St. Mary's Hospital	10	1
University Hospitals	22	17
Marshfield		
St. Joseph's Hospital	7	5
Milwaukee		
Columbia Hospital	10	0
Evangelical Deaconess Hospital	12	0
Milwaukee County Hospital	36	34
Misericordia Hospital	6	0
Mount Sinai Hospital	14	2
St. Joseph's Hospital	12	1
St. Luke's Hospital	10	1
St. Mary's Hospital	16	1
St. Michael's Hospital	8	0
Wausau		
St. Mary's Hospital	4	0
	229	74

[1] 1960 Results: National Intern Matching Program.
[2] JAMA, Vol. 174, No. 6, Oct. 8, 1960, Internship and Residency Number.

The Council on Medical Education and Hospitals of the AMA has approved graduate medical training programs for Wisconsin which include internships and residencies in the various medical specialties as follows:[2]

Internships	231
Residencies	570
	801

Of the total number of intern and resident positions approved by the AMA, 177 positions were occupied by Foreign House Staff[2] on September 1, 1960.

Concerned obviously by the effect of this situation in Milwaukee hospitals, the Medical Society of Milwaukee County in December, 1960 petitioned the Council by resolution to instruct the Wisconsin Delegates to the American Medical Association to introduce a resolution which asked for an investigation of the procedures and powers of the Council on Medical Education and Hospitals of the AMA in the establishment and approval of internship programs. This resolution also called for an answer to the question as to "why some Milwaukee hospitals were unable to attract interns and thus suffer the potential withdrawal of approval of the internship program?"

The Wisconsin delegation to the AMA held an informal meeting in Washington, D. C., with representatives of the Council on Medical Education and Hospitals of the AMA. This meeting resulted in unanimous agreement to withhold action on the resolution at that time in order that further information and suggestions might be gained regarding the problem.

This session was followed by a meeting in Milwaukee by two members of the AMA Council with representatives of both the Educational Committee of the Medical Society of Milwaukee County and the Commission on Hospital Relations and Medical Education of the State Medical Society.

The problem was further pursued by representatives of the State Society's Commission and the County Medical Society Committee at a nine-state meeting of medical societies with the AMA Council in Chicago on February 4, 1961. The conclusions of this meeting indicated the urgency of improved communications between the AMA Council and the several state medical societies and local hospitals approved for internship and residency programs. A number of other important questions were raised and will be pursued by the AMA Council.

It is apparent that the problem of adequate internship and resident training programs in Wisconsin involves all hospitals offering such programs, and affects the well-being of medical care throughout the state.

Accordingly the Executive Committee of the Commission on Hospital Relations and Medical Education of the State Medical Society is recommending early action in the area of postgraduate medical education in Wisconsin in order that some answer may be found to the slow, but steady, depletion of practicing physicians, especially in rural areas of the state. Since it appears that the ability of the state's hospitals to attract interns and residents is closely related to the number of physicians who ultimately decide to practice in Wisconsin, several actions are suggested:

1. Invite the Council on Medical Education and Hospitals of the AMA to meet with the State Medical Society's Commission on Hospital Relations and Medical Education to discuss in detail the Wisconsin postgraduate medical education problem.
2. Following the meeting with the AMA Council, call a meeting of the State Medical Society's

Commission with representatives from the medical staffs and administration of all hospitals in the state which have approved programs for internship and residency training.

3. Encourage medical staffs and hospitals to formulate well-rounded and attractive educational opportunities for the intern and resident so as to lift the "rating" of Wisconsin programs in comparison with similar training programs elsewhere.
4. Encourage young physicians completing various educational programs in Wisconsin hospitals to give greater consideration to the many possibilities for rewarding practice in Wisconsin.

Hospital Achievement Award

The Commission is currently seeking and evaluating information about the activities of Wisconsin hospitals to permit the granting of the 2nd Annual Hospital Achievement Award of the State Medical Society. In receiving such an award, a hospital is cited as one "whose facilities, personnel and medical staff have been so combined with the spirit of service and the art of helping so as to present an outstanding example of how the medical profession and the hospital working together provide superior patient care and public service in the fullfillment of the American tradition."

The recommendations of councilors and county medical society officers will be appreciated in making the evaluation of deserving hospitals and medical staffs.

REPORT OF COMMISSION ON STATE DEPARTMENTS

1960–1961

T. W. TORMEY, JR., M.D.
Chairman

T. W. Tormey, Jr., M.D., Madison, *Chairman*
A. M. Hutter, M.D., Fond du Lac, Division on Aging
H. A. Anderson, M.D., Stevens Point, Division on Chest Diseases
J. W. Nellen, M.D., Green Bay, Division on Handicapped Children
G. S. Kilkenny, M.D., Milwaukee, Division on Maternal and Child Welfare
E. D. Schwade, M.D., Milwaukee, Division on Nervous and Mental Diseases
H. W. Carey, M.D., Lancaster, Division on Public Assistance
Ray Piaskoski, M.D., Milwaukee, Division on Rehabilitation
Dayton Hinke, M.D., Richland Center, Division on Safe Transportation
L. M. Simonson, M.D., Sheboygan, Division on School Health
Meyer S. Fox, M.D., Milwaukee, Division on Visual and Hearing Defects

Summary of Recommendations

The Commission on State Departments recommends that:

1. A statewide conference on home care programs be developed by the State Medical Society of Wisconsin in cooperation with state and voluntary agencies to be held during 1961.
2. The State Department of Public Welfare be encouraged with the active assistance of the Division on Nervous and Mental Diseases to establish a series of workshops for physicians, county board members, trustees, hospital administrators and social workers involving didactic and clinical discussions of the care of patients in county mental hospitals.
3. The two Wisconsin medical schools be urged to develop more comprehensive undergraduate and postgraduate training regarding the medical use of hypnosis.
4. All physicians, in the interest of obtaining the utmost in professional understanding, be urged to attend a conference on the medical aspects of mental retardation to be held at Brooks Memorial Auditorium at Marquette University, Milwaukee on Wednesday, June 21.
5. All physicians use the "Prenatal Facts" form in their obstetrical work, participate in special conferences arranged by the Division on Maternal and Child Welfare, utilize teaching tapes prepared by Maternal Mortality Study Committee and conduct local studies on neonatal and perinatal deaths.
6. Emphasis be continued on securing earlier diagnosis of cancer, particularly in children, with a view to the application of the newer forms of cancer therapy especially valuable to the younger person.
7. All medical staffs of hospitals study carefully the Wisconsin Administrative Code of the State Board of Health for maternity hospitals and establish mechanisms to implement these rules and regulations locally.
8. Approval be given to the recommendations of the Division on Chest Diseases of the Commission on State Departments regarding the dual use of institutions for the care of the tuberculous and non-tuberculous patient. In summary these recommendations are:
   A. Admission policies in all institutions operating in a dual capacity should be determined in cooperation with the local county medical society.
   B. County medical societies should establish a county medical advisory committee to assist the county board, instruct trustees and medical director in the establishment of admission policies, visiting staff appointments and physician treatment privilege. It should meet periodically with the trustees and medical director of the institution, make an annual report on the operation of the institution to the county medical society and serve as a liasion committee to review complaints concerning professional relationships and medical practices in the institution.
9. County medical societies cooperate with the State Board of Health in its hypertension screening program on a continuing basis and that in planning the program at the county level a committee of the county medical society work with representatives of the State Board of Health to set up appropriate procedures and follow up.
10. Extensive mass screening of potentially exposed persons be undertaken by the county medical society in cooperation with public health authorities in any school or similar situation where a known case of tuberculosis has been revealed.

11. The standards for tuberculin testing recommended by the Division on Chest Diseases be approved.

Introduction

There is a tendency, in modern civic and professional life, to become so absorbed in the details of specific interests that changing concepts of broad implication are ignored or overlooked. States tend to become provincial in their attitudes. Departments within state government can easily and without intent become self-centered. Organizations, including medicine, are inclined to concentrate on the problems of the moment, and medical specialization increases the dangers of fragmenting the philosophy and structure of medicine.

The mechanism of the Commission on State Departments is one of the strongest bulwarks against such fragmentation and provincialism in medicine's relationships with state and voluntary agencies. The Commission continues to function effectively in the coordinating role established for it in 1956, serving to maintain order, continuity and strength within a series of inter-related divisions and between these special interests of medicine and similar interests outside the profession.

This report attempts to focus attention on the work of the Commission as a whole. To report every activity and concern of each of the ten divisions would triple or quadruple the detail. It should be recognized, also, that project priority changes from year to year, with divisions sharing the public attention and allocation of time, personnel and budget, as problems develop and solutions are found.

Conferences on Aging

Throughout 1960 and to date in 1961 a great deal of emphasis has been placed on problems of the aging at the local, state, and national levels. The Division on Aging played a leading role in the development and execution of the Wisconsin Governor's Conference on Aging Population held in June of 1960. This was followed by nine regional conferences in which area physicians were extremely active and cooperative.

Four Wisconsin physicians attended the White House Conference on Aging in January of 1961 as official delegates from Wisconsin. Two of these were members of the Society's Division on Aging.

Although the entire spectrum of problems of the aged and aging were discussed during the White House Conference, public attention was focused on controversy concerning plans to establish medical care of the aged as a provision of compulsory social security taxation. In this regard delegate Patricia F. Lanier, M.D., Kewaunee, a member of the division, commented on the White House Conference report that the social security proposal was almost inevitable:

> "If this be true, and if this be the thinking of the majority of the American people, then it seems to me that it behooves the American Medical Association, and medicine in general, to work very hard to safeguard integrity of medical care, and to safeguard the free choice of physicians. However, I think a great deal of education, and a great deal of thought by all must be applied to the study of this tax burden."

One of the major non-political recommendations of the White House Conference, as viewed by the division, related to the importance of adequate programs for home care of the elderly and chronically ill. The division is strongly of the opinion that many aged persons could live satisfactorily in their own homes if they had available low-cost part-time assistance in housekeeping chores, meal preparation, and personal health care. This involves some mechanism for providing homemaker and housekeeping services, "meals on wheels" and practical nursing services to selected patients who do not need all the services of a hospital or nursing home but who would otherwise need to be institutionalized.

Accordingly the division recommends that a statewide conference on home care programs be called at the earliest possible date. This will involve a cooperative effort of the State Medical Society and other state and voluntary organizations which have a legitimate interest in this problem.

County medical societies and individual physicians in their own communities are urged to give support to the American Medical Association's eight point program for the aging.

State Mental Health Advisory Committee

The State Mental Health Advisory Committee established by the 1959 session of the Wisconsin Legislature has undertaken a thorough review of the state Mental Health Act and all other legislation related to mental health problems. Several members of the Division on Nervous and Mental Diseases, including its chairman Doctor Schwade, have been named to serve either on the State Advisory Committee or its various subcommittees. A subcommittee of the division has initiated serious study of Wisconsin's commitment laws with special emphasis on an analysis of the M'Naughton and Durham rules. This subcommittee will continue its work, but in close cooperation with the state advisory group.

Standards for County Institutions

Assistance has been provided to the State Department of Public Welfare in the review of standards for county homes, infirmaries, general hospitals and public medical institutions and for county mental hospitals.

It is felt that medical care in county mental hospitals would profit from a greater understanding of medical care and rehabilitation on the part of physicians, hospital administrators, trustees, and social workers. Accordingly, it is recommended that the Division on Nervous and Mental Diseases in cooperation with the Department of Public Welfare, Division of Mental Hygiene establish a series of workshops designed to appeal to persons in these positions of responsibility.

Hypnosis

Problems concerning the use of hypnosis continue to concern the Commission. While it is felt that state laws are reasonably adequate to control the abuse of hypnosis by non-medical persons, it is recommended that the two Wisconsin medical schools be urged to offer more adequate undergraduate and postgraduate training in this field.

Mental Retardation

In another example of interdepartmental coordination, the Division on Nervous and Mental Diseases with the assistance of the Division on Maternal and Child Welfare and the Commission on Scientific Medicine is undertaking a conference on the medical aspects of mental retardation at Brooks Memorial Auditorium at Marquette University, Milwaukee on Wednesday, June 21. This will involve cooperation of the State Medical Society, the Wisconsin Council for Mentally Retarded Children, both university medical schools, the State Departments of Public Welfare and Public Instruction, the Wisconsin Association for Mental Health, the Wisconsin Academy of General Practice and the State Board of Health.

This is a conference especially keyed to the needs of physicians and for understanding of mental retardation. It is recommended that all physicians give careful consideration to attendance.

Orthopedic Programs

The orthopedic programs operated through the Bureau for Handicapped Children of the State Department of Public Instruction are continually being evaluated in terms of local service to eliminate duplication of the orthopedic clinic program in areas where appropriate local services are readily available. The policies of the Bureau for Handicapped Children are admirably designed to fill the gaps in local services not to supersede established and available facilities.

Bicillin Program

The House of Delegates in May of 1960 recommended revision of the Bicillin program to eliminate mandatory confirmation of a diagnosis of rheumatic fever through either the clinics or specialists. Doctor McIllece, the Bureau's medical director, has developed a program which she believes will meet the approval of the House of Delegates and which would be acceptable to the Bureau for Handicapped Children. This proposal will be discussed at a meeting of the Division on Handicapped Children set for March 4, 1961. The Commission will review the new mechanisms required to institute a revision of the program and it will submit a supplementary report on this matter to the House of Delegates.

Seat Belts

The installation and proper use of seat belts continues to be a major concern of the Division on Safe Transportation. It is again pressing for the establishment for state regulations requiring all state owned motor vehicles to be equipped with seat belts of approved standards. It recommends with equal enthusiasm the installation and use of seat belts by all citizens, including physicians.

Highway Safety

Members of seven Wisconsin organizations, including the Division on Safe Transportation and State Motor Vehicle Department officials have met with representatives of the Automotive Crash Injury Research Institute of Cornell University, New York to discuss a proposed study of automotive accident injuries in Wisconsin. Such a study could help reduce the incidence and degree of injury suffered by persons involved in automotive crashes.

A meeting of the division will be called in March to review a specific proposal from the Crash Injury Research Institute for such a study in Wisconsin.

At the same time the division will consider a number of problems related to driving under the influence of drugs and licensing of epileptics and former mental patients. A supplementary report will be prepared by the Commission for the House of Delegates.

School Health

The Division on School Health will participate in the National Conference on Physicians and Schools in Chicago, March 9, 10, and 11. It currently has under study problems related to weight control regulations associated with the high school wrestling programs under W.I.A.A. supervision; improved physical fitness programs; health education for prospective teachers; and increased participation in the development of local school health programs.

Kerr–Mills Implementation

Implementation of the Kerr-Mills bill in Wisconsin has received the attention of both the Divisions on Public Assistance and Aging. Doctor Carey, chairman of the Division on Public Assistance, is a member of the special committee of the Commission on Medical Care Plans appointed to represent the Society's interests in this vital legislation.

Projects Pending in Division on Visual and Hearing Defects

Pending projects relate to a survey of industrial vision testing practices, review of visual and hearing requirements for the licensing of motor vehicle operators and a review of Workmen's Compensation aspects of industrial vision laws.

Rehabilitation

The Society continues to co-sponsor the annual high school student essay contest conducted by the Governor's Committee on the Employment of the Physically Handicapped.

The Division on Rehabilitation also co-sponsors an annual meeting exhibit designed to provide the general practitioner with useful information in the rehabilitation of handicapped patients of all types.

Maternal and Child Welfare

The year 1961 has witnessed, in Wisconsin as elsewhere, a rise in the birth rate, and a slight increase in problems associated with infant survival. As in all branches of medical practice, as some problems are seemingly solved new ones arise to challenge the ingenuity and skill of the medical profession.

During this past year the Division on Maternal and Child Welfare has continued some programs initiated in the past and has directed its attentions to new areas which are of concern to the entire profession. This report must be brief, and we will mention, without a great deal of statistical detail, some of the major areas of concern and discussion the past twelve months.

Maternal Mortality Survey

Every year since 1953 this Division has reported briefly on a continuing study of each maternal death which occurs in Wisconsin. The survey has revealed many important factors associated with maternal demise which have been brought to the attention of the profession and hospital personnel through special teaching institutes, articles in the *Wisconsin Medical Journal*, special bulletins to hospitals, and in the form of tape recordings. Problems of anesthesia related to obstetrics, uncontrolled blood loss and special blood clotting problems, the potential hazards of certain drugs used to induce labor, proper management of toxemia, special obstetrical problems related to the cardiac and diabetic patient. . . . these and many more subjects have been presented in various ways by members of the Study Committee.

This past year a great deal of material based on review of cases has been published, and one interpretive institute was held in Wausau, attended by 120 persons, 60 of whom were physicians and the balance nurses, medical students and hospital personnel.

While the number of maternal deaths in a single year is not large (in 1960 fewer than 50 Wisconsin residents died in childbirth, and of these a number were classified as non-obstetrical: suicides, those killed in automobile accidents, murder, etc.) the study of maternal deaths has much to offer by way of ferreting out significant problems, and suggesting possible solutions for the benefit of all practitioners who are in any way concerned with obstetrics. It is hoped that during the ensuing year more tapes on these subjects can be provided hospital staffs and medical groups interested in the findings of the Maternal Mortality Study Committee.

As a corollary of the Maternal Mortality Survey, a one-page data sheet termed "Prenatal Facts" was prepared and published by the Study Committee in 1956. The sheet was designed to provide a cumulative patient record during the course of pregnancy, to be filed in the hospital during the last month of gestation. It is gratifying to report that many physicians are using this form with regularity, and some hospital staffs are requiring all physicians associated with the hospital to utilize the form and file a copy in the hospital prior to the expected date of delivery. It is felt by the Division on Maternal and Child Welfare that proper use of this form can do much to obviate potential problems of patient care in situations where the family physician is unable to attend the patient when admitted to the hospital on an emergency basis. The Division urges that all physicians concerned with the practice of obstetrics acquaint themselves with this form and use it in their practice. Samples can be secured from the office of the State Medical Society.

Neonatal Problems

The Division has mentioned in previous reports the growing importance of directing more attention to special problems of infant care which arise immediately following birth. Statistics indicate that this is a problem throughout the state, and naturally with mortality highest in the hospitals which experience the largest number of deliveries. A review of Tables 1 and 2 citing the percentage of premature live births and the perinatal mortality rate in the larger Wisconsin counties and selected hospitals indicates that this problem is statewide. A further study of the larger hospitals in Milwaukee County (Table 3) illustrates that the experience in relation to prematurity and both neonatal and perinatal deaths is rather generally distributed, except for Milwaukee County General Hospital which has an adverse experience largely based on the fact that it receives from other hospitals and adjoining communities a disproportionate share of "bad risk" cases, which often terminate in fatality.

Recognizing the increased importance of neonatal and perinatal mortality throughout the state, the Division this past year sponsored, cooperatively with the Wisconsin State Board of Health and the Wisconsin Academy of General Practice, a conference on "Problems of the Newborn," held at Milwaukee County General Hospital on June 2. This conference was extremely well attended, with over 300 registrants, including 119 physicians, 9 residents or medical students, and 103 nurses from 38 Wisconsin hospitals. The success of this meeting has prompted the Division to suggest a second conference of like character, which might be held in Wausau this summer or early fall.

The Division is pleased to report that some of the Milwaukee hospitals are directing their attention to special problems associated with neonatal and perinatal deaths, and are conducting individual hospital studies. To date there has been little over-all correlation to these studies, but it is hoped that in the future the data of each can be pooled and made available to the entire profession. The Division urges that other hospitals direct their attention to these special medical problems and determine in what way more infant salvage can be attained.

Special Problems in Prematurity

As a study of Tables 1, 2, and 3 indicate, premature births continue to remain a factor of concern. In the past the Division, cooperatively with the Bureau of Maternal and Child Health of the Wisconsin State Board of Health has sponsored small, regional, programs of doctors and nurses on the care of the premature. There is need that these programs be continued, and it is hoped that during the coming year some institutes of this character can be arranged. While the problems remain the same, there are always newer developments in equipment and care which should be brought to the attention of the medical profession and the hospital nursing staffs.

Poison Control

During the past several years the Division has worked closely with the pediatricians in Wisconsin and the State Board of Health in the development of poison control centers. Two such informational

TABLE 1—*Per Cent of Premature Live Births and the Perinatal Mortality Rate in Selected Wisconsin Counties, 1957–1959**

(By Place of Occurrence)

County	Total Live Births	Premature		Fetal Deaths	Neonatal Deaths	Total Perinatal	Perinatal Mortality Rate
		Number	Percent				
Brown	12,615	672	5.3	185	228	413	32.3
Chippewa	3,735	216	5.8	53	62	115	30.4
Columbia	3,109	186	6.0	26	47	73	23.3
Dane	17,966	1,062	5.9	192	293	485	26.7
Dodge	4,151	233	5.6	45	52	97	23.1
Eau Claire	5,194	288	5.5	55	82	137	26.1
Fond du Lac	5,238	273	5.2	69	74	143	26.9
Grant	3,283	180	5.5	36	37	73	22.0
Jefferson	4,089	213	5.2	43	53	96	23.2
Kenosha	6,316	418	6.6	88	129	217	33.9
La Crosse	7,168	494	6.9	108	126	234	32.2
Manitowoc	4,945	226	4.6	64	65	129	25.8
Marathon	5,661	347	6.1	62	87	149	26.0
Milwaukee	84,478	6,190	7.3	1,163	1,564	2,727	31.8
Outagamie	9,618	555	5.8	137	139	276	28.3
Racine	10,820	785	7.3	115	214	329	30.1
Rock	8,997	576	6.4	94	164	258	28.4
Sheboygan	6,313	359	5.7	82	111	193	30.2
Washington	3,344	200	6.0	47	63	110	32.4
Waukesha	6,884	396	5.8	71	104	175	25.2
Winnebago	7,437	461	6.2	94	126	220	29.2
Wood	6,997	416	6.0	89	131	220	31.0
TOTAL	228,358	14,746	6.5	2,918	3,951	6,869	29.7
Rest of State	62,679	3,606	5.8	842	996	1,838	28.9
STATE	291,037	18,352	6.3	3,760	4,947	8,707	29.5

* Counties with 1,000 or more live births per year.

centers have been in operation and have worked effectively in meeting emergency problems which arise. Many phone calls to the centers have assisted physicians in outlying areas to get the information needed on an emergency basis.

The Division is aware of efforts of the Wisconsin Pharmaceutical Association to help individual hospitals set up a poison control center by way of having a kit of supplies and instructions readily available to the hospital staff. An exhibit on this is presented as part of the Annual Meeting program, and all physicians are urged to study it, and if possible implement the program on a local level, in cooperation with hospital administrators.

Medical Aspects of Mental Retardation

The Division is aware of certain research being conducted at the University of Wisconsin Medical School to ascertain to what extent nutritional deficiencies in the early years of life might have bearing upon mental retardation. The Division urges cooperation of interested physicians in this project, which is being implemented through the Division on Nervous and Mental Diseases and the Foundation.

Cancer in Children

It is commonly thought that cancer is largely a problem of the aged, but it is of significance that in Wisconsin for the period 1955–1959 there were 612 deaths of children under 20 years of age attributed to malignant neoplasms. Of these the major causes of death were: Luekemias (263), brain and nervous (122), lymphosarcoma (47), and kidney (46). While nothing dramatic can at this time be done to change this statistical picture there are many developments in child care of the cancer patient which are of con-

TABLE 2—*Number and Per Cent of Premature Live Births and Rate of Perinatal Mortality in Certain Wisconsin Hospitals, 1957–1959*[1]
(By Place of Occurrence)

Hospital	Total Live Births	Premature		Fetal Deaths	Neonatal Deaths	Total Perinatal	Perinatal Mortality Rate
		Number	Percent				
Bellin Memorial (Brown)	3,692	190	5.2	56	70	126	33.6
St. Vincent's (Brown)	4,472*	230*	5.1*	59*	71*	130*	28.7
Madison General (Dane)	6,163	394	6.4	73	96	169	27.1
St. Mary's (Dane)	8,453	467	5.5	83	114	197	23.1
Luther (Eau Claire)	2,935	171	5.8	24	44	68	23.0
St. Agnes (Fond du Lac)	4,406	232	5.3	56	64	120	26.9
Kenosha (Kenosha)	3,125	203	6.5	49	60	109	34.3
St. Catherine's (Kenosha)	3,176	214	6.7	37	66	103	32.1
St. Ann's (La Crosse)	4,525	319	7.1	71	85	156	33.9
St. Mary's (Marathon)	3,602	236	6.6	36	62	98	26.9
Columbia (Milwaukee)	4,114	207	5.0	36	55	91	21.9
Evangelical Deaconess	6,037	383	6.3	84	86	170	27.8
Milwaukee Hospital	7,625	540	7.1	106	127	233	30.1
Misericordia (Milwaukee)	5,839	385	6.6	67	87	154	26.1
Mount Sinai (Milwaukee)	7,598	619	8.2	90	139	229	29.8
St. Anthony (Milwaukee)	4,919	465	9.5	88	93	181	36.1
St. Joseph (Milwaukee)	15,430	889	5.8	180	236	416	26.6
St. Mary's (Milwaukee)	5,810	427	7.4	71	117	188	32.0
Milwaukee County General	4,459	617	13.8	107	158	265	58.0
St. Luke's (Milwaukee)	3,665*	232*	6.3*	31*	42*	73*	19.8
St. Francis (Milwaukee)	6,083	367	6.0	78	96	174	28.2
St. Michael (Milwaukee)	3,352*	235*	7.0*	36*	54*	90*	26.6
St. Elizabeth (Outagamie)	5,084	316	6.2	63	74	137	26.6
St. Luke's (Racine)	4,704	361	7.7	44	93	137	28.9
St. Mary's (Racine)	4,031	303	7.5	49	84	133	32.6
Beloit Municipal (Rock)	4,443	273	6.1	45	88	133	29.6
Mercy (Rock)	3,660	231	6.3	28	54	82	22.2
Waukesha (Waukesha)	4,979	293	5.9	50	70	120	23.9
Theda Clark (Winnebago)	3,270	213	6.5	46	50	96	29.0
Mercy (Winnebago)	4,139	241	5.8	47	71	118	28.2
St. Joseph's (Wood)	4,101	261	6.4	50	77	127	30.6
GROUP TOTAL	157,891	10,514	6.7	1,940	2,683	4,623	28.9
Rest of Hospitals	131,317	7,590	5.8	1,722	2,160	3,882	29.2
STATE HOSPITALS	289,208	18,104	6.3	3,662	4,843	8,505	29.0

[1] Hospitals included are those that had 1,000 or more live births during 1959.
* This data based on a two-year experience instead of three years.

TABLE 3—*Number and Per Cent Premature of Live Births; Fetal, Neonatal and Perinatal Deaths in Selected Milwaukee County Hospitals, 1959*

Hospital	Live Births			Fetal Deaths			Neonatal Deaths			Perinatal Deaths		
	Term	Premature		Term	Premature		Term	Premature		Term	Premature	
		No.	%		No.	%		No.	%		No.	%
Columbia	1,221	66	5.13	5	9	64.29	3	15	83.33	8	24	75.00
Evangelical Deaconess	1,928	148	7.13	17	16	48.48	4	25	86.21	21	41	66.13
Milwaukee	2,206	182	7.62	15	7	31.82	7	29	80.56	22	36	62.07
Misericordia	1,800	121	6.30	12	7	36.84	9	15	62.50	21	22	51.16
Mt. Sinai	2,188	208	8.68	11	19	63.33	6	36	85.71	17	55	76.39
St. Anthony	1,344	124	8.45	15	17	53.13	6	20	76.92	21	37	63.79
St. Joseph's	4,750	296	5.87	25	16	39.02	16	56	77.78	41	72	63.72
St. Luke's	2,133	149	6.53	8	11	57.89	7	24	77.42	15	35	70.00
St. Mary's	1,755	138	7.29	8	11	57.89	8	18	69.23	16	29	64.44
Milwaukee County General	1,448	248	14.62	20	32	61.54	10	57	85.07	30	89	74.79
TOTAL	20,773	1,680	7.48	136	145	51.60	76	295	79.51	212	440	67.48

From Statistical Services Division, Wisconsin State Board of Health, 12–29–60.

cern to the medical profession. With newer advances in treatment and the importance of early diagnosis, all physicians are reminded to be on the constant lookout for cancer even in relation to children.

Also, the importance of general reporting of cancer cannot be over emphasized. While all cases of cancer are, by statutory requirement, to be reported to the State Board of Health, such reporting is very incomplete. Much can be gained by a statistical recording of this disease, and all physicians are urged to make known to either the State Board of Health or their own hospitals cases of cancer *when first diagnosed*, and not late in the disease, during terminal hospitalization.

It is hoped that during the next year or two special attention can be directed to the subject of cancer in children, in the form of teaching programs, articles, and other avenues of physician education.

Adoptions and Foster Care

While most of the attention of the Division has been directed to programs under the immediate jurisdiction of the Bureau of Maternal and Child Health of the State Board of Health, the Division has likewise served in an advisory capacity to the Division for Children and Youth of the Department of Public Welfare. This past year special attention has been directed to medical aspects of the adoption program of both the Department of Public Welfare and the various non-governmental adoption agencies. The Division has urged the establishment of a "medical advisor" for each agency, who would receive required medical reports on potential adoptive parents, and interpret these reports to the agency, as a means of establishing basic eligibility for the adoption of children. Suitable report forms have been devised and recommended for use by the various adoption agencies.

The Division for Children and Youth needs advisory assistance in all of its branch offices to consider special medical problems associated with their work. It is recommended that local county medical societies assist when such help is sought, both to advise as to proper fees for services and to suggest members especially qualified and interested to render such advisory service. The Public Welfare people want and need the cooperation of medicine, and it is important that this be given on a local level.

A Change in Personnel

Since 1935 Doctor Amy Louise Hunter has been Director of the Bureau of Maternal and Child Health of the Wisconsin State Board of Health, and she has worked closely with this Division. We regret very much her retirement, as of December 31, 1960, and we wish her many years of rewarding leisure and happiness in the years ahead. Her successor is Doctor James L. Wardlaw, Jr., and we anticipate from him the same cooperation and assistance which we have enjoyed in our associations with Doctor Hunter these many years. It is hoped that physicians and hospitals will establish close working relations with Doctor Wardlaw and his staff, so the services of the State Board of Health can be utilized to the utmost.

Recommendations of the Division on Maternal and Child Welfare

The Division recommends that during the ensuing year more local hospital staff attention be directed to infant mortality, premature care, and procedures in the care of the obstetrical patient which will help meet some of the basic problems commonly associated with maternal demise.

Specifically it is recommended that:

1. All physicians not now using "Prenatal Facts" in their obstetrical work, do so, and have this form used throughout the hospital in which they practice.
2. That physicians attend the special conferences arranged by the Division, when such conferences are in their area of the state.
3. That physician groups and medical staffs of hospitals utilize the teaching tapes which have been prepared by the Maternal Mortality Study Committee.
4. When the Milwaukee neonatal study has been completed it is recommended that the forms being used be purchased and individual studies on neonatal and perinatal deaths be conducted locally.
5. That efforts be made to secure an earlier diagnosis of cancer, particularly in children, and that such early diagnosis lead to the newer forms of therapy which will be most beneficial to the patient.
6. That all medical staffs of hospitals study carefully the Wisconsin Administrative Code of the State Board of Health for Maternity Hospitals, and set up mechanisms so these rules and recommendations can be implemented on a local level.

All that the Division can do is to "point with concern" and raise certain danger signals, which have to be translated into patient care programs on a local level. The Division feels that much has been accomplished in its various educational programs this past year, and urges cooperation on the part of physicians and hospitals' staffs as future programs of like character are developed.

Dual Institutions

In 1960 the Division on Chest Diseases, in its report to the House of Delegates, called attention to the dual use of institutions originally established for the sole care of tuberculous patients, and emphasized the opportunities for rehabilitation in the care of both tuberculous and non-tuberculous patients. The report further commented on the growing tendency to set up such facilities as "county general hospitals," and to place their supervision under a separate county board of trustees, often without any consultation with the county medical society in reference to admission policies and medical practices in the institution.

The Council and the House of Delegates charged the Division on Chest Diseases to conduct a further study of existing dual institutions, and to direct "particular attention to the medical staff organization problem, and others which may become apparent in its implementation."

This past summer the Division made a survey of the six dual institutions which have been approved by the State Board of Health, in an effort to secure basic information as to (1) the type of non-tuberculous patient admitted, (2) whether or not the institution has a medical director, (3) whether there is a visiting staff, and if so, how this staff is appointed, and whether or not appointments are approved by the county medical society, (4) whether the county medical society has formally approved of the policies for admission of non-tuberculous patients, (5) whether a non-tuberculous patient can be admitted to the hospital without the specific recommendation of his private physician, and (6) whether the patient's private physician has the privilege to treat his patient in the institution.

To secure a cross section of opinions, a copy of this questionnaire was sent to the chairman of the

board of trustees of each institution, one copy to the medical director, and one copy to the secretary of the county medical society, with this added notation: "Indicate the present 'working relationship' between the county medical society and the institution, and what changes might be made to improve medical supervision."

The results of this survey indicated that in several instances the secretary of the county society was not aware of any approval, even though so indicated by the medical director. In some instances the medical director's replies on appointments on the visiting staff varied with replies of the chairman of the board of trustees. From most of the replies it is apparent that either the respondent for the county medical society has not taken sufficient interest in the operation of the institution to determine whether or not approval of admission policies has been given, or where approval was given many years ago and this is not currently known, to members of the county medical society.

It is the conclusion of the Division that:

(1) No statewide policy concerning the admittance of non-tuberculous patients can or should be provided by the State Medical Society. Situations vary from county to county, but it should be emphasized that ADMISSION POLICIES IN ALL INSTITUTIONS OPERATING IN A DUAL CAPACITY SHOULD BE DETERMINED *IN COOPERATION WITH THE LOCAL COUNTY MEDICAL SOCIETY.*

(2) County medical societies in those counties with dual institutions, or contemplating such an institution, should offer to assist the County Board, the Trustees, and the Medical Director through the establishment of a County Medical Advisory Committee. The purpose of such a Committee would be to assist the Board, its Trustees and the Medical Director in the establishment of such admission policies, visiting staff appointments, and physician treatment privileges as would enable the institution to serve the best interests of the patients. The Committee should meet periodically with the trustees and medical director of the institution to review the effectiveness of the institution and jointly to make further recommendations when considered advisable. The Committee should be responsible to the county medical society and make an annual report on the operation of the institution to the society. It should keep the physicians of the county society informed of the existing admission, staff and other policies of the institution. It may serve as a liaison committee to review complaints received from physicians concerning their professional relationships with the institution, and bring such complaints to the attention of the governing body of the institution for appropriate correction and in conformance with acceptable standards and ethics of medical practice.

At the time the last report of the Division was prepared, an Attorney General's opinion on the authority and responsibilities of the State Board of Health in reference to the operation of dual institutions had been rendered, but not fully interpreted. It now appears clear that the State Board of Health has broad authority on all matters of health in respect to the operation of not only dual institutions but all medical institutional facilities within the state. Standards will be worked out jointly by the State Board of Health and the Department of Public Welfare for the county hospital-type of institution, including such dual facilities as are now being designated as "county general hospitals." It is important that county medical societies directly concerned become familiar with these standards when they are promulgated, and to see that the standards are adequately met in their county institutions.

Hypertension Program of State Board of Health

Two years ago the State Board of Health proposed that as an adjunct of its screening program for the detection of tuberculosis an associated program of taking blood pressures, and determining possible indications of early stages of hypertension, be employed. This was approved as a *pilot study*, and the Division on Chest Diseases was charged with the responsibility of evaluation of the program and making recommendations as to its continuance or discontinuance.

The Division has given thoughtful consideration to this program during the past two years of its operation, and it is prepared to submit its conclusions and recommendations:

1. The concept of "public health" is changing, and the practice of medicine should consider its proper role in a situation where true public health is more than the checking of communicable disease. The facilities of public health are ideally suited for mass screening programs which can be of tremendous service to citizens and physicians alike if properly correlated with the private practice of medicine, and cooperative medical programs developed on a local and/or county level.
2. The early detection of hypertension can be attained through mass screening techniques, and can logically be coordinated with a chest x-ray program, originally designed to detect tuberculosis.
3. Blood pressure readings are admittedly variable, and often reflect the condition of the patient at the particular moment the reading is taken, with marked variation at other times, but in spite of this an elevation of blood pressure *may* indicate an early case of hypertension which, if properly treated, may save the patient's life.
4. With screening procedures established so that known cases of hypertension are not referred back to the physician the percentage of referred cases with *suspected* hypertension will be significantly high, and indicates the importance of this procedure in terms of preventive medicine.
5. The State Board of Health routinely consults with and obtains the endorsement of the county medical society prior to initiating the hypertension screening program in any county. The program in no way interferes with the practice of medicine, and no physician is advised how to treat the patients referred to him.

In light of all known factors, it is recommended that county medical societies cooperate with the State Board of Health in furtherance of this program, and that in planning the program on a county level a small committee of the county medical society work with representatives of the State Board of Health to set up procedures for reporting and follow-up which are consistent with the resources and experience of the county medical society in other areas of public health.

Mass Screening Programs

In situations where active tuberculosis is detected and large numbers of persons are potentially exposed, such as in a school, extensive screening of

possible contacts is advised, and full cooperation should be extended by physicians in the area. The Division recommends that in all such situations the county medical society cooperate with public health authorities so that testing is not left up to the individual's willingness to secure a test through a physician of his choice. Complete and rapid testing is desirable after a known case of tuberculosis exposure is revealed, and the best method is mass screening, with the cooperative effort of all physicians in the area.

Standards for Tuberculosis Testing

In reference to tuberculin testing, either in the physician's office or on a cooperative basis as a part of a mass screening program the following standards are recommended for most effective measures of detection:

1. The tuberculin test should be done with the interdermal technique, using 0.1 milliliters of the solution.
2. The recommended test done should be .001 mgm. P.P.D.s (5 T.U.), intermediate dose P.P.D.
3. The tuberculin reactions should be read at 48 to 72 hours after the test is applied.
4. The tuberculin test should be recorded in millimeters of induration in its greatest transverse diameter of the reaction. (The measurement is made in the transverse diameter to the long axis of the arm).
5. IT IS RECOMMENDED THAT THE MANTOUX TEST BE USED BECAUSE THE PATCH AND OTHER TESTS ARE APPROXIMATELY ⅓ LESS ACCURATE.

Extension of School Employee Examination Program

By law all public, private, and parochial schools, through the 12th grade, are to require pre-employment and periodic re-check examination of school employees, to provide assurance that children in school are not exposed to active tuberculosis. The law was enacted in 1957, but there is no way of determining to what extent the schools of the state are adhering to the statutes. Upon recommendation of the Division and approved by the Commission on State Departments, efforts are being made to extend the law to cover all public and private institutions of higher learning (including vocational schools) and to amend the present statutes to require annual reporting of compliance, to the State Board of Health. It is hoped that this legislation will be passed, so that the same protection now being provided all children in public, private, and parochial schools through grade 12 will give this same assurance of protection to students through their college years.

Tuberculosis Is Still With Us

In spite of continued efforts of W.A.T.A., the State Board of Health, and the physicians of Wisconsin, the disease of tuberculosis is still with us, and while seemingly on the decline in terms of mortality the disease still represents a large and continuing public health problem. It is important that newer methods of treatment are made known to physicians, and that they assume direct and continuing responsibility for patients who are being treated in an ambulatory manner. It is evident that many who are being treated with drugs, so that the disease is repressed and is not communicable, regress due to lack of personal attention to a continued regimen of carrying out the physician's orders. To assume that a patient will continue daily use of prescribed drugs is placing too much faith on human nature, and every physician who assumes the responsibility of caring for a patient with tuberculosis, in an ambulatory manner, *must insist upon periodic check ups, tests, and chest x-rays.* While the Division on Chest Diseases recognizes the ability of all physicians to treat the disease of tuberculosis, it also recognizes that adequate patient care is time-consuming, and requires calling for patients for periodic review, which is difficult to do in the office of a busy physician. Therefore, it is important that any physician accepting the care of the tuberculous patient must be willing to assume responsibility for *positive* care, by way of insisting that the patient be seen regularly and kept on the regimen of drugs prescribed. Without continued and orderly re-evaluation of ambulatory patients the goals of tuberculosis control cannot be attained.

SUPPLEMENTARY REPORT OF THE DIVISION ON HANDICAPPED CHILDREN COMMISSION ON STATE DEPARTMENTS

Re: Revised Procedures in Bicillin Program

The House of Delegates at the Annual Meeting in 1960 requested revision of the state Bicillin program to eliminate *mandatory* confirmation of the original diagnosis of rheumatic fever by a clinic or board-certified specialist, and instead urged voluntary use of such confirmation techniques.

The Division on Handicapped Children, with the advice and cooperation of the Bureau of Handicapped Children of the State Department of Public Instruction, therefore recommends a revised program to make available reduced-rate Bicillin (free in cases of extreme financial hardship) for patients in financial need. The new proposal does not require a confirmation of diagnosis through either a specialist or a clinic sponsored by the Wisconsin Heart Association, University Hospitals or St. Mary's Hospital, Madison.

However, the Division strongly urges as did the 1960 House of Delegates that physicians *voluntarily* make use of the Heart Association clinics or the special clinics in Madison for their own referral procedures to specialists for consultation purposes. These clinics are ready to serve all physicians who wish their patients seen by cardiologists in attendance and if properly used can be of great assistance to patient and physician alike.

The New Program

In setting up revised procedures the Division wishes to emphasize that *the Bicillin program is designed to assist families in financial need.* If the physician feels that a payment of $6.00 to $8.00 per month for a daily tablet of Bicillin would impose a financial hardship upon the family of the patient served, he may encourage the patient to file with the Bureau for Handicapped Children a financial report which will be used as the basis for determining the extent to which Bicillin should be provided at reduced rates. These forms will be provided upon the request of the physician who desires to have his patient apply for assistance. *It will then become the responsibility of the family to provide the necessary financial data,* which is in keeping with all other programs of the Bureau where funds are available on the basis of financial need.

Under the new procedures, any licensed physician in Wisconsin may register his patient for participation in the Bicillin program by filing a Registration Report, based on the Jones Criteria Test for Rheumatic Fever. Continuation on the program is based

FOR CORRECTION
SEE p. 513

upon re-examination of the patient every six months and the filing of brief follow-up informational reports. Each child accepted under the program will be referred to the local public health nurse for follow-up every six months to assure that his or her medical needs are periodically re-evaluated by the physician.

It would not be the responsibility of the physician to establish eligibility on the point of financial need of the patient. This will be a responsibility of the family. *All that is asked of the physician is that he be selective, and not recommend that patients whom he believes able to pay $6.00 to $8.00 monthly for the drug, through regular retail channels, be considered as participants in the program.*

It appears that some physicians have not fully understood the intent of the Bicillin program, and have routinely requested that their rheumatic fever patients be provided the drug at reduced cost. Because the program is clearly intended to be restricted to families *in financial need* all current cases will be re-evaluated, and those financially able to pay for the medication through regular retail channels will be withdrawn from the supportive program.

Understanding the Cooperation Needed

The Division wishes to re-emphasize that the purpose of the Bicillin program is to make sure that all those needing the drug for control of rheumatic fever will have access to it, regardless of the financial status of the family. Physicians should be aware of the undesirability of providing assistance in the form of a subsidy, through a governmental agency, to all patients, regardless of their financial status, and *it is urged that physicians recommend that families apply for participation in the program only in cases where they (the physician) feel that the family cannot afford to purchase the drug at regular retail prices.*

It is also essential that the physician work closely with the public health nurse so that patients placed on the drug are contacted near the end of each six-month period, for re-evaluation and to determine whether medication should be continued.

The Division believes that the revised procedures will accomplish even more effectively than before, the objectives of the Bicillin program and at the same time encourage the voluntary use of clinics and specialists for consultation on cases involving rheumatic fever.

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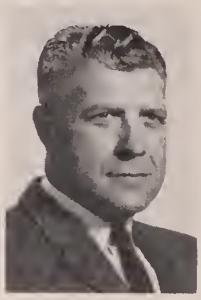

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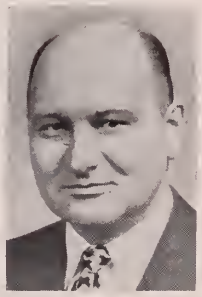
Mr. John Melcher, Director, Bureau for Handicapped Children, State Department of Public Instruction, Madison

Special Invitee

John B. Hitz, M.D., Member, Section on Ophthalmology and Otolaryngology Liaison Committee with Wisconsin Optometric Association, Milwaukee

REPORT OF COMMISSION ON MEDICAL CARE PLANS

1960–1961



E. M. DESSLOCH, M.D.
Chairman

E. M. Dessloch, M.D., Prairie du Chien, *Chairman*
H. A. Aageson, M.D., Oconto
E. L. Bernhart, M.D., Milwaukee
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W. T. Casper, M.D., Milwaukee
M. D. Davis, M.D., Milton
K. H. Doege, M.D., Marshfield
Milton Finn, M.D., Superior
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Nels A. Hill, M.D., Madison
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R. M. Moore, M.D., Frederic
E. J. Nordby, M.D., Madison
C. G. Reznichek, M.D., Madison
L. O. Simenstad, M.D., Osceola
John T. Sprague, M.D., Madison
F. H. Wolf, M.D., La Crosse
E. D . Sorenson, M.D., Elkhorn
L. H. Lokvam, M.D., Kenosha

While virtually all activities of the Commission on Medical Care Plans are related to "health insurance" in one form or another, its administration of Wisconsin Physicians Service as a division of the State Medical Society of Wisconsin has commanded its major attention.

The foremost objective of Wisconsin Physicians Service in 1960 was to bring into better balance the ratio between hospital benefit claims incurred and premiums earned. It was recognized that the attainment of that goal, combined with a favorable surgical-medical loss experience, would in all probability produce a satisfactory operational result.

That this objective was attained is evident from the financial figures which follow, taken from the attached year-end balance sheet which summarizes the financial records audited by Donald E. Gill & Company, Certified Public Accountants.

WPS Balance Sheet

"Total Reserves" (surplus) of Wisconsin Physicians Service as of December 31, 1960 increased to $1,454,938.14.

The *gain* in "Total Reserves" resulting *from operations* during 1960 was $148,787.53. This contrasted with *operating losses* of $941,682.98 in the prior year. "Total Reserves" were further increased by $114,639.08 as a result of appreciation in the market value of investments. The combined effect of these two factors was a growth in reserves of $263,426.61 over the prior year.

In addition to the regular operations reflected in the financial statements, WPS entered into the Federal Employees Program in conjunction with other Blue Plans throughout the country. The net result of this activity was an operating loss of $279.95 as indicated in the footnote to the Balance Sheet.

The greatest single factor contributing to this result is found in a study of claims liability.

"Benefits Incurred"

The relationship of benefits incurred to premium income is variously referred to as "loss ratio," "claims ratio" or "utilization ratio." But regardless of what it is called, it represents the percentage of income dollars which have been or remain to be paid to subscribers in contract benefits as of a given date.

To produce a satisfactory "insurance" operation, these ratios plus administrative costs must be less than 100% of earned premiums.

For the 12 months ended December 31, 1960, the ratio of surgical-medical benefits was 83.22% of income. This compared with 87.40% a year earlier, an improvement of 4.18 percentage points.

The ratio of hospital benefits to income in 1960 was 92.06%. This compares with 119.46% the previous year, an improvement of 27.40 percentage points. The difference accounts very largely for the wide variance between the financial operating results of the two years respectively.

In the years since its inception, through 1960, Wisconsin Physicians Service has paid benefits in the amount of $43,869,276.70!

This is indeed a tribute to "the doctors' plan" and to the voluntary, prepaid non-profit forms of health insurance which were first pioneered by the State Medical Society of Wisconsin nearly fifteen years ago.

Claims Administration

Under the general direction of its Medical Consultant, claims administration practices of WPS are under constant review.

Contract (policy and endorsement) terminology has been the subject of much study. Revisions intended to clarify coverage intent will continue to be made at the earliest times practicable.

A point which appears frequently to be overlooked is that the "denial" of coverage in certain instances is in no way related to the question of good medical practice. The type and extent of the benefits provided is a matter of contract. The rates charged for such benefits are in proportion to their utilization under the terms and conditions of such contracts. An increased awareness of this fact by subscribers, physicians and hospitals has proven to be extremely helpful in attaining a better understanding of claims administration practices.

County Advisory Committees are to be commended for their intense interest in carrying out both the provisions and intent of the Special Service ("no fee schedule") contract . . . and for the many other ways in which their support of the WPS insurance program is evidenced.

Administrative Expense

The ratio of administrative expense to earned premiums continued its downward trend. That ratio in 1959 was 13.24%. In 1960 it was 12.08%, well within the budget objective.

Investment and Other Income

Investment income is an extremely important part of the total financial picture.. In 1960, investment and other income of $82,822.94 accounted for more than half of the increase in total reserves, a situation not at all unusual in the voluntary, non-profit prepaid insurance field.

Earned Premium Income

The 1960 budget was based on an estimated earned premium income of $9,000,000. This objective was exceeded by $144,159.83.

Earned premiums in 1961 are estimated at $10,000,000.

Enrollment

"Enrollment" figures are frequently used by Blue Cross and Blue Shield Plans as a measurement of growth. In the sense of numbers of subscribers and dependents covered, this yardstick is generally reasonably accurate.

On the other hand, an increase in premium dollar volume does not necessarily also indicate increased enrollment or greater contract count. This is so because of the effect of rate changes and other factors on premium income.

As to Wisconsin Physicians Service, there was no substantial change in contract count during 1960 . . . even though earned premiums exceeded those of the previous year by $1,456,577.33.

Although rate adjustments contributed heavily to an increase of nearly 20% in premiums, the "upgrading" of benefits by many groups was another extremely important consideration. This included the "elevation" of surgical-medical coverage from Plan "B" to Plan "A" and from Plan "A" to Special Service, and the addition of hospital as well as major medical benefits to the basic surgical-medical contract.

WISCONSIN PHYSICIANS SERVICE

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

FINANCIAL STATEMENTS FOR DECEMBER 1960

Condensed Balance Sheet December 31, 1960

ASSETS		
Cash on Hand and in Banks		$ 360,240.28
Receivables		446,089.85
Government Securities—Market Value	$2,745,684.16	
Other Investments	310,111.30	
Total Investments		$3,055,795.46
Fixed Assets—Net		111,862.10
Accruals and Prepaid Expenses		34,426.79
Total Assets		$4,008,414.48
LIABILITIES AND RESERVES		
Payables		$ 59,540.04
Provision for Unreported and Unpaid Claims		1,370,000.00
Premium Received but not Earned		1,106,546.13
Other Liabilities		17,390.17
Total Liabilities		$2,553,476.34
Total Reserves		1,454,938.14
Total Liabilities and Reserves		$4,008,414.48

Condensed Statement of Income and Expenses

	December 1960	12 Months Ending December 31, 1960	12 Months Ending December 31, 1959
Earned Premium Income	$778,368.07	$9,144,159.83	$ 7,687,582.50
Benefits Incurred (Paid and Estimated)	634,803.52	7,973,509.84	7,688,325.30
Available for Expenses and Reserves	$143,564.55	$1,170,649.99	$(742.80)
Administrative Expenses	101,966.84	1,104,685.40	1,017,590.17
Net Operating Income	$ 41,597.71	$ 65,964.59	$(1,018,332.97)
Investment Income	11,763.45	82,822.94	90,935.24
Total	$ 53,361.16	$ 148,787.53	$(927,397.73)
Special Non-Recurring Expenditures			14,285.25
Available for Reserves	$ 53,361.16	$ 148,787.53	$(941,682.98)

Note: In addition to regular operations, WPS has entered into a nationwide Federal Employees Program in conjunction with other Blue Plans. The net result of this activity, for which separate accounting is maintained, was an operating loss of $279.95 which would result in a reduction of this amount from "Reserves."

WISCONSIN PHYSICIANS SERVICE

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

SUMMARY OF EARNED INCOME AND BENEFITS INCURRED

12 Months Ending December 31, 1960	Earned Premium Income	Benefits Incurred	Benefits Incurred as % of Income	Available for Expenses and Reserves
Surgical-Medical	$5,032,557.93	$4,188,191.43	83.22	$ 844,366.50
Hospital	4,111,601.90	3,785,318.41	92.06	326,283.49
	$9,144,159.83	$7,973,509.84	87.19	$1,170,649.99
12 Months Ending December 31, 1959				
Surgical-Medical	$4,663,531.28	$4,075,768.54	87.40	$ 587,762.74
Hospital	3,024,051.22	3,612,556.76	119.46	(588,505.54)
	$7,687,582.50	$7,688,325.30	100.00	$ (742.80)

Except as to hospital benefit contracts, which are tabulated separately, the extension of additional benefits by rider does not influence the enrollment count. This defect in the present system of relating premium volume and work-load to contract count is presently under study.

Acquisition—Retention

With strong emphasis on the adequacy of the rates at which contracts are written or renewed, the acquisition and retention of business has been an up-hill climb. Simply stated, Wisconsin Physicians Service will not knowingly write or renew contracts at other than actuarially sound rates.

The past year's improvement in operating results does not justify a change in this policy. There is no lasting value in meeting "price" competition simply for the sake of increasing volume.

State of Wisconsin Employees

Effective April 1, 1960, WPS was awarded basic surgical-medical coverage on State of Wisconsin employees who availed themselves of such benefits. While also awarded the major medical coverage on those employees desiring it (without State participation in the cost), a number of State departments elected to continue such coverage with a previous carrier.

As of December 31, 1960, WPS covered 17,513 State employees and their families for base surgical-medical benefits and 6,614 for major medical benefits.

The Insurance Governing Board has authorized the renewal of the coverages carried by WPS effective April 1, 1961.

An open enrollment held in February resulted in the addition of about 4,200 major medical contracts effective May 1. This open enrollment has been extended into March. As of this writing, the further increased number of enrollees is not known.

Federal Employee Program

Under the terms of a reallocation arrangement, 3,955 surgical-medical contracts of Federal employees are now "assigned" to WPS for servicing.

In recent weeks, much of the misunderstanding which existed earlier with respect to the filing of Physicians Service Reports for the rendering of professsional services to Federal employees and their dependents has been clarified. It appears now to be generally known that physicians may send such reports to the Blue Shield Plan of their choice, just as the patient may select the doctor of his choice.

Hospital Relations

In an endeavor to provide personal services to hospitals and physicians in matters relating to WPS, the Commission on Medical Care Plans authorized expansion of the services of the Administrator, Hospital Relations, to include such personal contacts. The need for accelerated WPS professional relations activities has been recognized for some time, especially in interpreting the WPS Hospital Rider to administrators of Wisconsin hospitals.

From September through December numerous contacts with physicians and hospitals were made. In addition, physicians were contacted at county medical society meetings and during a three-day circuit teaching program.

Personal visits to hospitals were the result of specific questions or misunderstandings about the administration of the benefits of the WPS Hospital Rider. It is believed that positive public relations with hospital administrators was an important by-product of such visits.

This program will be continued in 1961. The Commission believes it extremely desirable to promote a sound and continuous program of WPS-professional relations.

Another function of Administrator, Hospital Relations, is to maintain close liaison with the Wisconsin Hospital Association, American Hospital Association, American College of Hospital Administrators and the Division of Hospitals and Related Services of the State Board of Health. Frequent contact, as well as attendance at meetings of these groups, is maintained.

Medicare

Following the restoration on January 1, 1960 of previously "cut-back" benefits, Wisconsin Medicare payments to physicians totaled $387,000 (5,300 cases) for the year. In excess of half of the dollars expended continue to be paid for obstetrical services. Slightly over 1,300 different physicians treated Service dependents once or more in 1960.

The report to Congress by the ODMC stated that this program of medical benefits for Service dependents had met with wide acceptance by military personnel. Wisconsin physicians can take a "pat on the back" for their patient handling of required "red tape" type reporting in addition to providing the best quality of medical service to dependents.

Minnesota and Iowa extended their use of Wisconsin facilities to include the preparation of IBM checks for their Medicare payments. These services, plus those to the states of Indiana, North Dakota and South Dakota, are reimbursed at cost.

Veterans Administration

The only remaining function of the State Medical Society in its contract with the Veterans Administration is the negotiation of a fee schedule between it and the physicians of Wisconsin. The administrative functions of the home town care program have been completely absorbed by the offices of the Veterans Administration.

Wisconsin Health Service

Many aspects of the Kerr-Mills Act and efforts toward its implementation in Wisconsin have had the attention not only of the Commission on Medical Care Plans, the staff and consultants, but of the several commissions and committees concerned with one facet or another of the health needs of senior citizens.

Countless hours have been devoted to drafting and re-drafting legislative proposals and in discussing with other interested groups the best means of implementing such legislation in keeping with its original purpose.

A separate report on developments to date has been submitted to the Council. The membership at large will be kept fully informed.

Other activities of "Wisconsin Health Service" will have attention after its principal project . . . the implementation of the Kerr-Mills Act . . . has been reasonably completed.

Future Planning

If history continues to repeat itself, as it has long had a habit of doing, the health insurance scene in the years ahead will be replete with change and challenge.

What happens in Washington and what takes place legislatively and economically in our own State Capital will obviously strongly influence the outlook for the continued growth of the whole voluntary health insurance system. The need for keeping abreast of the times, of remaining constantly aware of the public pulse, is self-evident. What looks like a progressive, new idea today can be made old-fashioned and obsolete by tomorrow's developments.

The greatest challenge to providers of voluntary health insurance lies in meeting the true health insurance needs of the public in the most economical, effective and efficient manner possible. The accomplishment of that objective is complicated by a very

practical fact of life . . . that what the public *demands* and what it really *needs* are not always one and the same.

There was a time, not long ago, when most "health insurance packages" paid close to "first dollar" sickness benefits, including home calls by physicians and the visits of patients to doctors' offices. For reasons of cost and otherwise, this practice has, by and large, been discontinued. A substantial segment of the population has, in fact, gone a step further by evidencing marked interest in coverage for "catastrophic medical expense" only.

By contrast, an even larger segment has continued to demand the highest possible schedule of benefits at the lowest possible cost. Plans of insurance calling for subscriber participation in health care costs through the deductible and co-insurance mechanisms are presently neither wide-spread nor popular. Because that picture may change rapidly, marketing experiments and the ability to move quickly into new fields is a practical necessity. In the process of transition from one approach to another, such basic considerations as adequate rates, claims administration and the long-range financial interests of the Plan and its subscribers must never be overlooked.

In continuing its pioneering activities in the field of voluntary health insurance benefits, WPS has an obligation not only to study markets and demands but a responsibility to promote only those forms of benefits which are consistent in all respects with sound insurance principles. This, briefly, is the basis upon which our plans for the future will continue to be developed.

RESOLUTION NO. 1

Introduced by: Dane County Medical Society

WHEREAS, In many counties of Wisconsin there are licensed physicians who are not members of the county or state medical societies; and

WHEREAS, On many occasions these non-member physicians utilize the facilities of their county medical society and of the State Medical Society of Wisconsin; therefore be it

Resolved, That these non-member physicians be expressly invited to join and participate in the activities of their county medical society and in the State Medical Society of Wisconsin; and be it further

Resolved, That participation in the activities of each county medical society and in the State Medical Society of Wisconsin be limited to members and invited guests.

RESOLUTION NO. 2

Introduced by: Dane County Medical Society

WHEREAS, Comments of the Membership of the State Medical Society of Wisconsin increasingly suggest that some consideration be given to limitation of tenure of office at all levels of that Society; therefore be it

Resolved, That this House of Delegates acknowledge this sentiment by considering some recommendation of policy as to tenure of office within the State Medical Society of Wisconsin be that office elective or appointive.

RESOLUTION NO. 3

Introduced by: Dane County Medical Society

WHEREAS, The county medical society is the basic unit of the State Medical Society of Wisconsin; therefore be it

Resolved, That knowledge of and participation in the affairs of a member's county medical society be considered a requisite for his candidacy for office in the State Medical Society of Wisconsin, be that office elective or appointive.

RESOLUTION NO. 4

Introduced by: Dane County Medical Society

WHEREAS, As yet the Blue Shield Plans have not been subjected to arbitration according to the Insurance Code of the State of Wisconsin; therefore be it

Resolved, That the management survey portion of 1960 Resolution H (as amended) be promptly implemented by the Speaker of the House of Delegates as directed by that session of the House of Delegates.

RESOLUTION NO. 5

Introduced by: Dane County Medical Society

WHEREAS, Edward R. Annis, M.D., of Miami, Florida has so ably represented Medicine in his television debates with Senator Humphrey and on two occasions with Mr. Walter Reuther; and

WHEREAS, Doctor Annis has on numerous other occasions so ably presented the viewpoints of the American medical profession in reference to socialization of medicine; and

WHEREAS, Edward R. Annis, M.D., in behalf of the State Medical Society of Wisconsin, has on several occasions spoken to representatives of organized medicine in Wisconsin, as well as to the general public through radio and television, again presenting medicine's stand in reference to socialized medicine; therefore be it

Resolved, That the House of Delegates of the State Medical Society of Wisconsin spread upon its minutes this resolution of our appreciation for his efforts in this regard which have been above and beyond reasonable effort; and be it further

Resolved, That this resolution in suitable form be sent to Edward R. Annis, M.D.

RESOLUTION NO. 6

Introduced by: Columbia—Marquette—Adams County Medical Society

WHEREAS, There has been a marked increase in the number of non-medical insurance policies (life and health) written by the various carriers; and

WHEREAS, There has been a corresponding increase in insurance inquiries to physicians regarding the health of these applicants; and

WHEREAS, These requests are made on various forms and often with no remuneration offered for this service; therefore be it

Resolved, That a standard report form and a standard fee of $3.00 be established to cover the above service.

RESOLUTION NO. 7

Introduced by: Brown County Medical Society

WHEREAS, As recent publicity has indicated, an increase in American Medical Association dues is imminent; and

WHEREAS, Members of the Brown County Medical Society desire ample justification for such dues in-

crease be explicitly set forth to all members of the American Medical Association before said increase becomes mandatory; therefore be it

Resolved, That the Delegates to the American Medical Association House of Delegates from the State Medical Society of Wisconsin be instructed to obtain such ample justification for said contemplated dues increase; and be it further

Resolved, That lacking such ample justification any dues increase be specifically and vociferously opposed by said named delegates from the State Medical Society of Wisconsin.

RESOLUTION NO. 8

Introduced by: The Sixth Councilor District

WHEREAS, Under the present bylaws of the State Medical Society of Wisconsin no consideration is given to multiplicity of committee portfolio chairmanships maintained by one individual member of the State Medical Society of Wisconsin; and

WHEREAS, Circumstances have found one or more individual members of the State Medical Society of Wisconsin holding multiple portfolio chairmanships; and

WHEREAS, Significant criticism and unrest has been noted among the rank and file of the membership in said State Medical Society of Wisconsin concerning multiplicity of portfolio occupation; and

WHEREAS, Such multiplicity of portfolio occupation does potentially deprive the State Medical Society of Wisconsin of the introduction of new competent talent to its governing bodies; therefore be it

Resolved, That this House of Delegates does now duly instruct the legal counsel in cooperation with the staff of the State Medical Society of Wisconsin to draft such changes in the bylaws, specifically designed to:

(1) Designate major State Medical Society of Wisconsin Committees, Divisions, or Councils (major committees).

(2) To rewrite the bylaws of the State Medical Society of Wisconsin appropriately to eliminate multiplicity of portfolio occupation as designated in such committees; and be it further

Resolved, That such draft be submitted to the next regular or special meeting of the House of Delegates for consideration.

RESOLUTION NO. 9

Introduced by: The Sixth Councilor District

WHEREAS, Under the present bylaws of the State Medical Society of Wisconsin, no limitation of tenure is placed upon members of the Council of the State Medical Society of Wisconsin; and

WHEREAS, Significant criticism and unrest has been noted among the rank and file of members of the State Medical Society of Wisconsin concerning such limitless tenure; and

WHEREAS, It is felt by many and has become axiomatic that there is no "indispensable man" in society; therefore be it

Resolved, That this House of Delegates does now duly instruct the legal counsel in cooperation with the staff of the State Medical Society of Wisconsin to draft such changes in the bylaws to limit tenure of councilors to three consecutive terms; and be it further

Resolved, That such draft be submitted to the next regular or special meeting of the House of Delegates for consideration.

RESOLUTION NO. 10

Introduced by: Douglas County Medical Society

WHEREAS, Tuberculosis, the diagnosis and treatment thereof, presents a considerably changing problem today compared to past years; and

WHEREAS, The morbidity and mortality from tuberculosis is constantly decreasing; and

WHEREAS, The population of tuberculosis hospitals is decreasing; and

WHEREAS, Per capita costs are rising due, among other things, to decreased population; and

WHEREAS, Larger institutions appear to have the following advantages:

1. Better medical care.
2. Staff of physicians to consult on each case rather than one alone.
3. Permanent staff composed of all phases of phthisiology including physiologists, surgeons, pathologists, internists, etc.
4. Supply resident training.
5. Support pulmonary physiology stations.
6. Produce greater purchasing power at decreased costs.
7. Support research.
8. Afford better supervision and control of medical activities.
9. Produce considerable monetary savings by unifying all efforts.
10. Support ancillary functions in a better manner at reduced expense, such as:
    a. Occupational therapy.
    b. Rehabilitation.
    c. Social services.
    d. Psychiatric care and services.
    e. Special services. (entertainment, religious services, etc.)

WHEREAS, Long term hospitalization appears, to many, to be more successfully controlled at greater distances from home; and

WHEREAS, The nucleus for fewer state institutions is already present in the county institutions; and

WHEREAS, More modern systems utilize the state plan; and

WHEREAS, The county plan as practiced in Wisconsin today is a product of decades past; and

WHEREAS, The state plan of centralization permits more modern, up to date, better controlled laboratories; and

WHEREAS, The Douglas County Medical Society presented a similar resolution two years ago suggesting state control of tuberculosis hospitals; and

WHEREAS, A resolution pertaining to state control of tuberculosis was approved by the House of Delegates of the State Medical Society of Wisconsin and no subsequent action was taken; therefore be it

Resolved, That the House of Delegates of the State Medical Society of Wisconsin direct the officers and the Council of the State Medical Society of Wisconsin to enlist the aid of the governor and the legislature to formulate a plan of study of state tuberculosis control that should result in definite recommendations based upon a complete and adequate study of both state and county tuberculosis control.

RESOLUTION NO. 11

Introduced by: Douglas County Medical Society

WHEREAS, There is an ever increasing need for adequate general practice residency training programs; and

WHEREAS, Many general practice residencies are unfilled and many have inadequate progressive and integrated training programs; and

WHEREAS, The present two-year family practice pilot program of the American Medical Association fails to adequately prepare the young physician to do general practice in his own community; and

WHEREAS, Each segment of organized medicine has, and still, determines the minute details and over-all content of their respective training programs; therefore be it

Resolved, That this House of Delegates of the State Medical Society of Wisconsin recommends that the Council on Medical Education and Hospitals of the American Medical Association formulate other pilot two-year progressive training programs which are acceptable to the American Academy of General Practice, the only national association exclusively representing general practice.

RESOLUTION NO. 12

Introduced by: Monroe County Medical Society

WHEREAS, American medicine has during the past century through selfless devotion and unswerving loyalty to the principle of freedom and human dignity made contributions to the health and well-being of our society unrivaled by any other profession or group; and

WHEREAS, This unparalleled record of service continuing even today is not being brought to the full attention of the American people with the greatest force and effect; and

WHEREAS, At the same time the medical profession is being victimized through a nationwide program of distortion, untruth and half-truth designed to discredit the physician and his professional organizations; and

WHEREAS, This program of vilification is jeopardizing the nation's health by discouraging young men and women from entering the profession of medicine, creating doubt as to the integrity of a noble profession, disparaging the importance of a close personal patient-physician relationship and discouraging self-reliance in favor of government aid and control; therefore be it

Resolved, By the members of the Monroe County Medical Society that the State Medical Society of Wisconsin undertake an expanded program of public information designed to demonstrate its determined efforts to bring the finest quality of health care to all the people at the most reasonable cost, to explain medicine's viewpoint of sound economic planning for health care and to seek the preservation of the system of medical care that has made this health progress possible; and be it further

Resolved, That this program be implemented by the House of Delegates of the State Medical Society of Wisconsin through an assessment of $50.00 per member for the year 1961–62.

ANNOUNCEMENTS

Pamphlet

CATARACT AND GLAUCOMA—HOPE THROUGH RESEARCH. Public Health Service Publication No. 793 and Health Information Series No. 99. Single copies may be obtained without charge from the PHS. Orders under 100 are 15 cents a copy from the Superintendent of Documents, Government Printing Office, Washington 25, D.C.

The pamphlet describes the two principal causes of blindness—cataract and glaucoma—and how the ailments may be arrested or prevented.

Films

THE DIAGNOSIS OF HIDDEN CONGENITAL ANOMALIES. A new teaching film available free of charge, except for return postage and insurance, by writing the Department of Professional Education, The National Foundation, 800 Second Avenue, New York 17, N. Y. At least three weeks' advance booking is requested.

The film was prepared by Virginia Apgar, M.D., M.P.H., Director, Division of Congenital Malformations, The National Foundation, and L. Stanley James, M.B., (N.Z.), Department of Pediatrics, College of Physicians and Surgeons, Columbia University. It demonstrates to physicians and nurses a simple method of examination, done in the first few minutes after birth, for the diagnosis of choanal atresia, laryngeal stenosis, tracheoesophageal fistula, intestinal obstruction, rectal atresia, cleft palate, and diaphragmatic hernia.

EXTERNAL CARDIAC MASSAGE. Produced by Smith, Kline & French as the fourth in a series of medical teaching films for professional audiences, the 21 minute, color and sound film is available on a free-loan basis from local representatives of SK&F.

External cardiac massage is a recently developed technique for restarting hearts which have stopped beating—without opening the chest. This film shows how the technique substitutes externally applied pressure for the rhythmic contractions of normal heart muscle, thereby maintaining circulation at a level sufficient to sustain life.

VOYAGE OF THE SS HOPE. A story of medical training and teaching in Southeast Asia is depicted in a new and dramatic 27-minute color motion picture documentary made available by Project HOPE. It tells the story of the American people's floating medical center currently in Indonesia.

Available for interested groups and television showings. Inquiries may be directed to: Film Department, Project HOPE, 1818 M Street, N.W., Washington 6, D.C.

Bibliography

TOXOPLASMOSIS. A bibliography of literature 1956–September 1960. Compiled by Dorothy Bocker, M.D., National Library of Medicine, Public Health Service, Washington, D.C.

Reprints

Reprints of four Combined Clinical Staff Conferences of the National Institutes of Health, published in the *Annals of Internal Medicine*, are now available to interested physicians upon request to: Clinical Center Information Office, National Institutes of Health, Room 1–N–226, Bldg. 10, Bethesda 14, Md.

- UNEXPLAINED DEATH IN A PATIENT WITH LEUKEMIA
- RECURRENT PULMONARY DISEASE IN A CHILD
- PROBLEM IN DIFFERENTIAL DIAGNOSIS
- PRIMARY AMYLOIDOSIS

MEDICOLEGAL INFORMATION

AVAILABLE

Individual physicians or county medical societies may wish to make use of several informational materials and speakers on topics relating to medical-legal problems of physicians.

FILMS

The following films are available upon request to the State Medical Society of Wisconsin. Please allow at least two weeks advance notice if possible. These films were produced by Wm. S. Merrill Co. under direction of the American Medical Association, American Bar Association and American Hospital Association.

"Medical Witness"—Dramatically illustrates use of medical witness in court, providing do's and don'ts for effective testimony. Black and white, sound, 30 minutes.

"Doctor Defendant"—Suggests how the physician can prevent professional liability suits; shows county medical society grievance committee in action. Black and white, sound, 30 minutes.

"Man Who Didn't Walk"—Legal and medical aspects of personal injury case. Shows lawyers for plaintiff and defendant as they establish evidence from physicians, pretrial conference, and summation to jury. Black and white, sound, 30 minutes.

"A Matter of Fact"—Discusses the need for an adequate medical examiners' system versus the presently common coroners' system. Black and white, sound, 30 minutes.

"No Margin for Error"—Portrays certain aspects of physician-hospital activity bearing upon professional liability. Black and white, sound, 30 minutes.

"Chemical Tests for Intoxication"—Deals with the subject of chemical tests for intoxication and the introduction of the results of such tests in court. Black and white, sound, 30 minutes.

SPEAKERS

County medical societies interested in obtaining speakers on medicolegal subjects may contact the State Medical Society, Box 1109, Madison 1, Wisconsin (phone ALpine 6–3101), or the State Bar Association of Wisconsin, 402 West Wilson Street, Madison, Wisconsin (phone ALpine 7–3838).

LITERATURE

Copies of the following materials are available upon request to the State Medical Society of Wisconsin:

★ Interprofessional Code

★ Medicolegal Consent Forms (see January 1958 Blue Book issue of the *Wisconsin Medical Journal*)

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★ Medicolegal Aspects of Blood Transfusions

★ Medicolegal Aspects of Blood Grouping

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Followup Study on Patients with Hodgkin's Disease Seen at the University of Wisconsin Between 1948 and 1954

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THIS IS A report on the results of treatment of Hodgkin's disease at the University of Wisconsin Hospitals between 1948 and 1954. A total of 121 consecutive cases was reviewed, 25 of which were available for a 10-year, the remainder for a 5-year, followup study. The diagnosis was confirmed on all reported cases by histopathologic examinations of biopsy specimens at the Wisconsin State Laboratory of Hygiene by Dr. William D. Stovall or the Surgical Pathology Department of the University of Wisconsin Hospitals by Dr. Walter Jaeschke. The patients in this series were treated under the supervision of Dr. E. A. Pohle.

The high fatality rate, the presence of multiple sites of involvement, and the absence of any proven infectious agent have led most investigators to believe that Hodgkin's disease is neoplastic in origin.[1] We adhere to this view.

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Presented at the annual meeting of the Wisconsin Radiological Society, September 1960.

Clinical Material

Symptoms and signs as observed in our patients are recorded in Tables 1 and 2.

The clinical picture was quite variable. Painless lymphadenopathy in single or multiple sites was the most frequent initial complaint, being present in 83.3% of our patients (Table 1). Involvement of hilar and mediastinal nodes was present in 47.1% and led to cough, dyspnea, cyanosis and dysphagia. Pleural effusion resulting from actual involvement of the pleura or mediastinum was observed in 9.9% of these patients. Superior vena cava obstruction was seen in 5 patients. Lesions involving the pulmonary parenchyma were often difficult to distinguish from associated inflammatory disease, especially when cavitation occurred. Enlarged retroperitoneal nodes were sometimes associated with low back pain. The presence of constitutional symptoms, when all the obvious areas of disease were under control, favored the implication of retroperitoneal lymphadenopathy as the cause. The actual diagnosis of retroperitoneal lymphadenopathy was made in 5.8% of our patients, a figure which probably reflects the difficulty of establishing its presence (Table 2).

TABLE 1—*Initial Complaints in 121 Hodgkin's Patients*

	Number	Per Cent
Cervical nodes	71	58
Weight loss, anorexia, fatigue	26	21.4
Axillary nodes	16	13.2
Fever and chills	13	10.7
Supraclavicular nodes	8	6.6
Inguinal nodes	7	5.8
Backache	6	4.9
Pruritis	4	3.3
Routine chest x-ray	4	3.3
Chest pain	4	3.3
Abdominal mass	4	3.3
Superior vena cava obstruction	2	1.6
Breast	2	1.6
Subcutaneous nodules	2	1.6
Abdominal pain	1	.8
Dyspnea	1	.8

TABLE 2—*Clinical Manifestations in 121 Hodgkin's Patients*

	Number	Per Cent
Cervical nodes	85	70.2
Mediastinal and hilum	57	47.1
Axillary	50	41.3
Spleen enlargement	44	36.4
Liver enlargement	42	34.7
Lung	38	31.4
Inguinal	36	29.7
Supraclavicular	24	19.8
Bone	23	19.1
Pruritis	23	19.1
Abdominal mass	18	14.9
Pleural effusion	12	9.9
Skin	11	9
Cord compression	7	5.8
Retroperitoneal	7	5.8
Herpes zoster	6	4.6
Superior vena cava syndrome	5	4.1
Renal parenchyma	5	4.1
Associated pregnancies	8	3.3
Breast lesions	3	2.5
Associated TBC	3	2.5
Jaundice	2	1.6
Renal obstruction	2	1.6
G. I.	1	.8
Adrenal	1	.8
Ovary	1	.8
Splenectomy	1	.8

Jaundice resulted from involvement of the hepatic parenchyma or obstruction secondary to lymphadenopathy in the area of porta hepatis. Enlargement of the liver was noted in 34.7% of our series. Hemolytic anemia was seen occasionally. Anemia resulting from decreased erythropoiesis was commonly observed. The symptoms of bone involvement frequently preceded the ability to demonstrate the lesions roentgenographically. They were most frequently observed in the vertebrae, ribs, sternum, pelvis, humerus and femur. Bone involvement was demonstrated in 19.1%, or 23 of our patients, but was not seen as an initial symptom.

Extradural masses led to cord involvement as manifested by pain, paresthesias, and paralysis in 7 patients.

Clinical splenomegaly was noted in 36% of our cases. Other sites of involvement included skin, breast, kidney, adrenal, ovary and gastrointestinal tract.

Herpes zoster was not an infrequent complication, being observed in 6 patients. We think that this is a manifestation of decreased resistance rather than actual neoplastic involvement of the nerve roots. The incidence of herpes zoster has also been reported to be higher in patients receiving x-ray therapy for other conditions. Pruritus was an extremely difficult symptom to control and was usually a later manifestation but occurred as an initial symptom in 4 patients. Eight pregnancies occurred in 4 patients in our group. All of these patients delivered normal children with the exception of one stillbirth. No adverse effects were noted in the mothers.

As the disease advanced constitutional symptoms progressed. Weight loss, fatigue, anorexia, fever, and debilitation ensued and were noted in most patients. Such symptoms were noted in 21% of our patients as the initial symptom. A high incidence of concurrent infection was noted in patients with advanced disease. Miliary tuberculosis was observed in two cases at autopsy.

Pathology

The nodes usually had a firm rubbery consistency but were quite hard when fibrotic or occasionally soft when reaching large dimensions. They were usually discrete although at times were matted. On section they exhibited varying degrees of fibrosis and on occasion underwent spontaneous central necrosis. Microscopically the involved tissues exhibited varying degrees of architectural destruction from only minimal to complete obliteration of the normal lymphoid follicles. The fibrous tissue was occasionally hyalinized and the capsule considerably thickened.

The cell population was composed mainly of lymphocytes and reticulum cells, one or the other cell forms predominating. Plasma cells, eosinophils and neutrophils were frequently seen. The most characteristic feature was the Reed–Sternberg cell, the presence of which Jackson and Parker[1] thought was necessary to make the diagnosis. Almost all of our patients showed such cells, but their absence did not preclude, in our opinion, the diagnosis of Hodgkin's disease. Only a few exceptional patients had equivocal Reed–Sternberg cells, but other features were characteristic enough to support the diagnosis. The histologic characteristics were quite variable and

subtleties in the histopathology, while not affecting the establishment of the diagnosis of Hodgkin's disease, afforded considerable difficulty in further subclassification. Once the diagnosis was established it was not customary to do another biopsy, so conclusions regarding changing histology could not be made in this group of patients.

Our series exhibited a 1:1 sex ratio. This represented a higher percentage of females than heretofore reported, the highest previous incidence being 44% females reported by Shimkin et al.[2] in patients seen after 1945. He reported a 32.5% incidence in patients seen between 1914 and 1945 and pointed out that although the ratios were not statistically significant, a similar trend to an increasing percentage of females had been noted in chronic granulocytic and lymphocytic leukemias and in lymphosarcoma. The age distribution (Fig. 1) corresponded to that previously reported[2,3] with the peak incidence in the third decade.

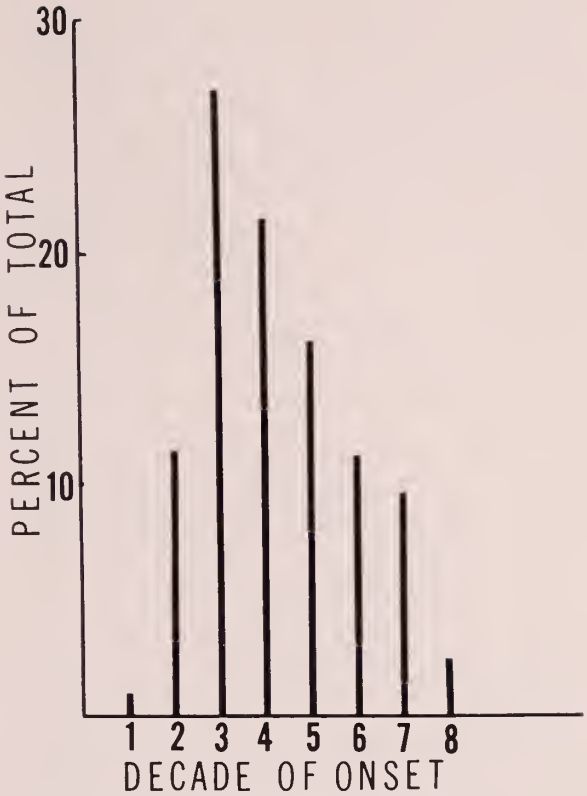

Fig. 1—Age distribution in 121 patients with Hodgkin's disease.

Treatment

The policy at this institution was to treat only the involved sites except in the case of cervical node involvement where the supraclavicular and cervical areas were treated en bloc. In a sense this represented prophylactic radiation of adjacent node bearing areas. In all other instances the treatment fields were localized to include only the involved group; however, wide margins were utilized to insure inclusion of the entire chain of lymph nodes. Prior to 1957, doses in the range of 1,000 to 1,500 r/t with 200 KVP radiation and HVL 1.1 mm Cu were used. In treating the neck and supraclavicular areas 2 or 3 fields are employed with care taken to shield the larynx. More recently doses in the range of 2,500 r/t with a half value layer of 3.2 mm Cu have been used.

The presence of constitutional symptoms was considered sufficient indication for treatment of the retroperitoneal node bearing areas in the absence of evident disease elsewhere. Following such treatment we occasionally observed subsidence of fever, return of appetite and relief of distressing pruritus.

The approach to treatment of large mediastinal masses causing respiratory obstruction was somewhat different. Much smaller doses were used initially (in the range of 50 to 100 r/t) in an attempt to avoid reactive edema and further encroachment on the respiratory tree.

In cases of actual or inminent compression of the spinal cord, treatment was directed at the appropriate level, localized clinically or by myelography. When laminectomy was performed, it was followed by irradiation. The best results were obtained in cases of short duration prior to therapy.

Isolated bony lesions usually responded well with decrease in pain and some subsequent recalcification. We believe that the addition of the nitrogen mustards has provided a valuable adjunct in the treatment of Hodgkin's disease. When therapy caused severe bone marrow depression, periodic white blood cell counts were made. Except in extenuating circumstances radiation therapy was discontinued if the white blood cell count fell below 2,000 per cubic millimeter. This rarely occurred during treatment of peripheral lymph node masses but was more common when treating the abdominal and retroperitoneal areas.

The question of surgical excision of localized Hodgkin's disease has received considerable mention in the literature.[4-6] Four of the patients in our series underwent surgical excision followed by postoperative radiation

TABLE 3—*Survival Data on 121 Hodgkin's Patients*

Year	No. of cases	Survival in Years									
		1	2	3	4	5	6	7	8	9	10
1948	5	3	2	2*	1	1	1	1	1	1	1
1949	20	11	9	5	5	4	2	1	1	1	0
1950	21	14	12+	8	7	4	3	2	2*	1	
1951	18	12	9	8	7	6+	5	5	4		
1952	23	13+	8	8	8	6	4	3			
1953	14	7+	4	4	4	4+	2				
1954	20	12	11	8	7	7					
No. of Cases	121	121	121	121	121	121	101	87	64	46	25
Survivors		72	55	43	39	32	17	12	8	3	1
% Survivors		59	45	35	32	26	17	14	12	7	4

* 1 patient died unrelated causes.
+1 patient lost to follow-up.

TABLE 4—*Survival According to Stage of Disease*

		No. of Patients	Percentage of all Patients	5-year Survivors	Average longevity in months
Stage I	living	12	9.9		90
	dead	7	5.8		50.5
TOTAL		19	15.7	15 (79%)	75.4
Stage II	living	3	2.5		79.3
	dead	21	1.4		30
TOTAL		24	19.9	7 (29%)	36.2
Stage III	living	2	1.7		109.5
	dead	76	62.8		19.6
TOTAL		78	64.5	10 (12.8%)	21.9

therapy. Three of the patients were alive without evidence of disease at 5, 7 and 8 years. The fourth patient died in 5 months of generalized disease. The consensus regarding the surgical approach was that candidates must be scrupulously selected and that postoperative irradiation was indicated. Although our own series is too small to draw any conclusions, we hesitate to recommend surgical excision in view of the good results obtained in the treatment of localized disease by irradiation alone.

Classification

We have followed in this study the clinical classification as advocated by Peters and Middlemiss[7] and divided the patients into three groups. The distribution of these patients is indicated in Tables 3 and 4. In Stage I we included all patients who at the time of treatment had the disease confined to one group of lymph nodes. A total of 19 patients (14.8%) was so classified. In Stage II were included those patients who had the disease confined to two adjacent lymph node bearing areas such as cervical and axillary, cervical and mediastinal, inguinal and deep iliac, femoral and inguinal. (Table 5). Approximately 20% of the patients were in this stage. All the remaining patients were classified under Stage III.

The clinical staging of Hodgkin's disease has proved to be of value in both prognostic evaluation and comparison of survival data[7,8] when dealing with a series. In the individual patient it is difficult to offer any specific prognosis on the basis of the stage of the disease or the histology.

Results

The over-all 5-year gross survival rate was 26.4% and the average survival was 33.4 months. The figures were computed from the date of the first University of Wisconsin hospitalization. Of the 121 patients, only 2 died of unrelated causes. Both of these patients had autopsy examinations which revealed no evidence of Hodgkin's disease. An average of 17.2 months elapsed between the onset of symptoms and the first hospitalization with a range of 0 to 133 months. Several patients had received treatment elsewhere prior to referral to this hospital. Five patients were lost to follow-up at various periods. These

TABLE 5—*Survival in Different Age Groups*

Age	10–19	20–29	30–39	40–49	50–59	60 and over	Total
Number of Patients	11	30	28	23	12	17	121
Average Survival (Mos.)	35.6	34.4	33.3	47.6	18.9	30.1	33.4
No. in Stage I	2	6	3	5	0	3	19
No. in Stage II	3	5	5	4	4	3	24
No. in Stage III	6 (56%)	19 (63%)	20 (71%)	14 (61%)	8 (66%)	11 (65%)	78

were assumed to be dead following their last hospital visit, although no confirmation of their death could be found in the records of the Bureau of Vital Statistics of the State of Wisconsin. The year-by-year survival figures are shown in Table 3. Close correlation is shown between the five-year survival figures reported from the University of Minnesota and our figures[3, 9] (Fig. 2).

The five-year survival figures in the different groups are shown in Table 4. The percentage of five-year survivors in Stage I correlated with those reported by Peters and Middlemiss[7] and by Nice and Stenstrom[9]; however, the Stage II survival rate demonstrated considerable variation: 29% of our group as compared to 90% in Nice and Stenstrom's series. When the five-year survival figure was combined for Stages II and III, the resultant figures were similar: 16.4% in the University of Wisconsin group compared to 18.6% in the University of Minnesota group.

The differences in Stage II survivors could presumably be accounted for by errors in classification. The staging was determined in retrospect by review of hospital records. Examination of the records of Stage II patients revealed that 11 of the patients returned in less than a year with evidence of generalized disease, so that the disease progressed quite rapidly or the patients were actually in Stage III when first seen. Their average survival was 10 months. All of these patients exhibited systemic manifestations when seen originally (Stage II B), supporting Peters' observation[7] that the presence of constitutional symptoms signifies a poor prognosis. If these patients were removed from the remaining 13 Stage II A patients, an average survival of Stage II patients without constitutional symptoms of 56 months was obtained. The five-year survival of Stage II patients without constitutional symptoms was 74%.

The five-year survival rate in Stage III was 12.8%, or 10 patients of a total of 78, which is comparable to that reported by others.

The results were better in females than in males as evidenced by an average survival of 39.9 months in 61 consecutive female patients as compared to 60 males whose average survival was 26.7 months. Expressed as five-year survival, the figures were 34.4% for females and 18.3% for males.

There was no statistical correlation between age of onset and survival (Table 5).

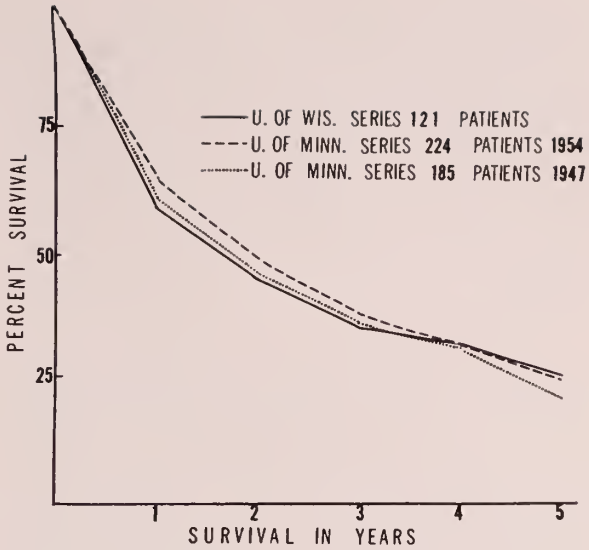

Fig. 2—Five year survival data.

Discussion

Radiation therapy is generally considered to be of great value in the clinical management of Hodgkin's disease. Most investigators now recommend dose levels of 2,500 r or more over 2 to 4 weeks as calculated to the center of the tumor mass provided the disease is confined to a single or two adjacent node bearing areas. Larger tumor masses may require a higher dose.

In Stages I and II, Peters and Middlemiss[7] have demonstrated an increase in survival rates following prophylactic irradiation to uninvolved lymph node bearing areas adjacent to involved sites. Hynes and Frelick[10] have treated all lymph node bearing areas in two courses separated by a three-month interval delivering 1,000 to 1,200 r to each group and 1,800 r to grossly involved nodes. Of 7 patients so treated, 5 with the disease confined to one group of lymph nodes survived 10 years or longer. Nice and Stenstrom[9] reported survival data comparable to those obtained by Peters and Middlemiss without prophylactic radiation to uninvolved adjacent lymph node areas and with dose levels of approximately 2,000 r/t in two weeks.

Gelhorn and Collins[11] reported that remission periods were longer in patients receiving alternate courses of radiation therapy and nitrogen mustard than in those receiving radiation therapy alone. The total amount of radiation was reduced and the economic burden lightened in patients receiving combined therapy. They were unable to demonstrate a

significant increase in the four-year survival figure. Cook et al.[12] demonstrated longer survivals and a decrease in first-year mortality rates along with an increasing three-year survival figure in patients treated with combined therapy compared to those receiving irradiation alone. Triethylene melamine provided results comparable to the other mustards[13] and had the advantage that it could be given orally and caused less nausea and vomiting.

Our studies suggest that quite satisfactory five-year survival figures can be obtained with relatively conservative radiation dose in patients classified as Stage I or II A without constitutional symptoms and signs. These results were obtained without prophylactic irradiation to adjacent lymph node areas clinically free of disease. Nevertheless, it is now recommended that in such cases the minimal tumor dose reach or exceed 2,500 r/t in two weeks since such dose levels are well tolerated with high energy radiation. Whether better results will be obtained with these higher dose levels remains to be seen, since the optimal tumor dose and time relationships are not yet firmly established.

A large number of patients randomly selected from each stage and assigned to the different treatment schedules would have to be treated and followed for more than five years before statistically significant results could be expected. No such studies have been found in the available literature.

The value of prophylactic radiotherapy to clinically uninvolved regions does not seem to be firmly established in early cases.

In patients with multiple sites of involvement and/or constitutional signs and symptoms, lower dose levels appear to be satisfactory particularly when combined with chemotherapy.

Summary

The clinical manifestations, age and sex distribution, and the survival data have been presented for 121 patients with Hodgkin's disease. The value of clinical staging for assessing prognosis in a series of patients has been demonstrated.

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BOOKLET ON ESOPHAGEAL SPEECH

A booklet on esophageal speech titled "Your New Voice" is available through the American Cancer Society. The booklet was written by William F. Waldrop and Marie A. Gould, both of whom have an extensive background in speech training.

Dr. Robert J. Samp, medical director of the Wisconsin Division, American Cancer Society, states that patients learning esophageal speech are quite complimentary on the results obtained from reading the book, and this should be of special interest to physicians who have patients who have lost their voices by virtue of surgical intervention into the larynx.

Physicians interested in this booklet may obtain one at no cost by writing the American Cancer Society, Wisconsin Division, Box 1626, Madison 1, Wisconsin.

The Theoretical Basis and Clinical Application of the Prothrombin Time and Prothrombin Consumption Time

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THE ONE-STAGE prothrombin time is of particular interest to Wisconsin physicians because it was in this State that the test was perfected.[1] It played an important role in the isolation of bishydroxycoumarin (Dicumarol) from spoiled sweet clover hay at the University of Wisconsin,[2] and it was the first employed in the control of the new drugs in therapy at Wisconsin General Hospital.[3] By means of the test, the first new clotting factor to follow the formulation of the classical theory of coagulation was discovered at Marquette University[4] and two types of congenital hypoprothrombinemic states were established.[5] Because the test is simple, it was quickly introduced into the clinical laboratories; and in several Wisconsin hospitals, it has been used since 1938 without any changes from the original technique using acetone-dehydrated rabbit brain as the thromboplastin reagent.

The prothrombin test has two major uses: for diagnosis and for controlling anticoagulant therapy. Before the test became available, hypoprothrombinemia was not recognized as a clinical entity and was not distinguishable from hemophilia. At the time the prothrombin time was developed, only thromboplastin, calcium and prothrombin were recognized as factors in the generation of thrombin. A prolonged prothrombin time was therefore interpreted as a decrease of prothrombin. It is now known that in addition to prothrombin other plasma constituents, namely, factors V, VII and X (labile, stable and Stuart–Prower) are essential in the production of thrombin and that when any one of them is decreased, the prothrombin time becomes prolonged. The basic test is actually an over-all measurement of the prothrombin complex which can be called prothrombin activity (Table 1).

Fortunately, the prothrombin time can be made specific for the various factors of the prothrombin complex by very simple modifications. This has proved to be of great clinical value. In the basic test, the fresh oxalated plasma is mixed with the thromboplastin reagent and to this mixture calcium chloride is quickly added and the clotting time accurately recorded. Normal plasma will give a clotting time of 12 seconds. When such a value is obtained, it establishes that all factors of the prothrombin complex are normal. It is necessary, however, to use a satisfactory thromboplastin reagent. Acetone-dehydrated rabbit brain has been successfully employed for over 20 years. It can be prepared easily and is also available commercially.

The first modifications consist in diluting the plasma with an equal volume of oxalated rabbit plasma deprothrombinized by adsorption with $Ca_3(PO_4)_2$. This plasma supplies an excess of factor V but no prothrombin or factors VII and X. If the basic prothrombin

TABLE 1—*The Prothrombin Time as An Over-all Measure of Prothrombin Activity*

Prothrombin Time Prolonged by a Deficiency of	Cause
Prothrombin	Congenital Vitamin K deficiency Drugs (Dicumarol, etc.) Liver damage
Factor V (labile)	Congenital Liver damage
Factor VII (stable)	Congenital Vitamin K deficiency Drugs (Dicumarol, etc.) Liver damage
Factor X (Stuart–Prower)	Congenital
Fibrinogen	Congenital Obstetrical Fibrinolysis

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TABLE 2—*Differential Diagnoses of the Hypoprothrombinemic States*

	Normal sec.	Hypoprothrombinemia Vera sec.	Factor V Deficiency sec.	Factor VII Deficiency sec.
Basic test	12	60	50	70
With added factor V*	12	60	12	70
With added factor VII**	12	55	50	12

*To 0.05 ml. of plasma, 0.05 ml. of deprothrombinized rabbit plasma was added.
**To 0.1 ml. of plasma, 0.01 ml. of aged serum was added.

TABLE 3—*The Relationship of the Depression of Factor VII and Prothrombin in Dicumarol Therapy*

Patient: 60 year old man date	Average daily dose mg.	Prothrombin Time	
		Basic sec.	With added aged serum sec.
Nov. 28, 1960	62.5	24	17
Dec. 20	62.5	25	17
Jan. 3, 1961	62.5	37	19
16	58.5	32	17
Feb. 6	58.5	21.5	13
20	67.0	22	12.5
Mar. 6	75.0	32	17
20	75.0	38	19
Apr. 3	62.5	24	15.5

time is prolonged but made normal by mixing with deprothrombinized rabbit plasma, a decrease of factor V is proved. If no correction is obtained, it indicates that the defect is due to lack of prothrombin, factor VII or X.

The second modification consists in adding one-tenth volume of normal aged serum to the plasma before adding thromboplastin and calcium. Aged serum is rich in factors VII and X, low in prothrombin and devoid of factor V. If, therefore, the prothrombin time is corrected, the deficient component is factor VII or X. Prothrombin is not corrected by adsorbed rabbit plasma, aged serum or the combination of both.

By means of these simple tests, the hereditary bleeding diseases due to defects in the factors of the prothrombin complex can be differentially diagnosed. These diseases are, however, rare and therefore of only limited interest in general practice. Of far greater importance are the acquired hypoprothrombinemic states. In the initial study which resulted in the discovery of factor V, it was observed that the new component was reduced in experimental liver injury,[4] and this was confirmed clinically.[6] Relatively little work has since been done correlating liver injury with changes in various clotting factors; but with the availability now of simple and reliable laboratory methods for estimating the various factors quantitatively, it may be possible to obtain new information on liver function.

Particularly interesting and significant are the newer studies on the effect of drugs such as Dicumarol on the prothrombin complex. The increase of the prothrombin time is not caused solely by a decrease of prothrombin. As a matter of fact, factor VII is affected much sooner and to a much greater extent than is prothrombin itself. Actually, a significant decrease of prothrombin is observed only after factor VII is greatly depressed. The basic prothrombin time measures factor VII in the patient receiving Dicumarol but with the second modification, i.e., by adding aged serum to correct for factor VII, the true prothrombin concentration is determined. A fairly close association between the depression of factor VII and prothrombin has been observed in a small series of cases (Table 2). This study is now being intensively pursued because such information may become useful in developing a more critical means for controlling oral anticoagulant therapy.

The Prothrombin Consumption Time

The term thrombokinase or as it is more familiarly known in America, thromboplastin, had a vague meaning until 1947. Some investigators considered the platelets as the source of thromboplastin; others regarded it as a plasma constituent. The solution to this puzzle was solved by the development of a new test: the prothrombin consumption time.[7] It was found in confirmation of other investigators[8,9] that when hemophilic blood clotted, the serum remained rich in prothrombin; likewise, when platelet-poor plasma clotted, the resulting serum had a high concentration of unconsumed prothrombin. However, when platelet-poor normal plasma was mixed with platelet-rich hemophilic plasma and the mixture clotted, the prothrombin remaining in the serum was low. This clearly indicated that a factor lacking in hemophilic plasma reacted with platelets to form thromboplastin and that the amount formed determined how much prothrombin was consumed. Later it was found that additional factors participated in the generation of thromboplastin. This has not changed the basic principle of the prothrombin consumption test.

TABLE 4—*The Prothrombin Consumption Time as the Measure of the Thromboplastin-Producing Factors*

Prothrombin Consumption Time Low in Deficiency of	Cause
Platelets	Congenital (rare) Acquired
Factor VIII (thromboplastinogen)	Congenital (hemophilia A)
Factor IX (PTC deficiency)	Congenital (hemophilia B) Drugs (Dicumarol, etc.)

The basic concept of the prothrombin consumption test is that when blood is placed in a glass test tube, a series of reactions occur resulting in the generation of intrinsic thromboplastin which, with other plasma factors, brings about the conversion of prothrombin to thrombin. The amount of prothrombin remaining in the serum is an indirect measure of the quantity of thromboplastin generated. The test is, therefore, an over-all measure of intrinsic thromboplastic activity and is not specific for any one factor. The outline in Table 4 serves as an aid to interpret the results of the test.

The prothrombin consumption test is almost as simple as the one-stage prothrombin time and requires only one additional reagent, namely, deprothrombinized rabbit plasma. This reagent supplies fibrinogen and factor V which are needed for the determination of prothrombin in serum. Technically, the test is simple. Blood is clotted under standardized conditions and the prothrombin of the serum measured by the one-stage prothrombin time. Fibrinogen and factor V, which serum lacks, are supplied by deprothrombinized rabbit plasma. The latter reagent can be easily prepared or obtained commercially.

This test is most valuable in the diagnosis of hemophilias A and B. By a simple modification, the two hemophiliacs can easily be differentiated. Normal aged (PTC) serum is rich in factor IX which is lacking in hemophilia B but is devoid of factor VIII (thromboplastinogen). Therefore, the addition of serum to the blood will correct the defective prothrombin consumption if the disease is hemophilia B but not if it is true classical hemophilia (Table 5).

Prothrombin consumption is low in thrombocytopenia. This serves as a check on the platelet count and also yields valuable information on the quality of platelets.

In very mild hemophilia the prothrombin consumption test may be normal as well as the clotting time. In certain other rare conditions, such as factor X deficiency, the test may be abnormal. Recently, modifications of the test have been developed which increase its sensitivity and also make it more definitive.[10] The modifications, however, are more complex and require additional reagents.

TABLE 5—*Differentiation of Hemophilias A and B by Prothrombin Consumption Time*

	Clotting Time min.	Prothrombin Consumption Time	
		Basic sec.	With added aged serum* sec.
Hemophilia A			
Severe	65	8	8
Mild	10	11	10
Hemophilia B			
Severe	90	10.5	19
Mild	9	14	39
Normal	5-8	16-35	16-35

*To 1 ml. of blood, 0.05 ml. of aged serum was added.

Summary

The one-stage prothrombin time and the prothrombin consumption test because of their simplicity and usefulness should be available in almost all hospital laboratories. By means of these two tests and a few minor modifications, most of the hemorrhagic diseases can be diagnosed and differentiated. The prothrombin time serves as the most widely employed test for controlling oral anticoagulant therapy.

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A Practical Approach to the Problem of Iron-Deficiency Anemia

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THERE ARE three important points to remember when considering the subject of iron-deficiency anemia.

1. Even in its mild form iron-deficiency anemia is important because it indicates a decrease in the total amount of hemoglobin available for carrying out vital physiologic functions. These include the carrying of oxygen to the tissues, the removal of carbon dioxide from them, and its function of acting as a buffering agent.
2. The finding of an iron-deficiency anemia may lead to the diagnosis of a serious, unsuspected, underlying disease involving either actual blood loss or suppression of hemoglobin synthesis.
3. Iron-deficiency anemia per se is neither a disease nor a diagnosis. Rather, it is an objective determination, nonspecific in nature, that must be properly interpreted and utilized as a step in the diagnostic technic. A thorough search for the cause of iron-deficiency anemia is mandatory before embarking on the simple procedures involved in its symptomatic treatment.

This all leads up to the question of how to make a clear-cut diagnosis of iron-deficiency anemia.

The outline in Table 1 is useful in determining what etiologic factor might be responsible for the anemia. Usually the diagnosis is not difficult and can be made with simple technics which can be performed in the office as well as in hospital laboratories.

Great advances have been made in the laboratory diagnosis of the anemias. Now the laboratory provides a sound and exact basis for the diagnosis of iron-deficiency anemia. The technics are not difficult but must be constantly standardized and accurately applied if the determinations are to be reliable. These determinations include hemoglobin, hematocrit, red cell count, mean corpuscular hemoglobin, mean corpuscular hemoglobin concentration, mean corpuscular volume and the blood smear both to establish the diagnosis of iron-deficiency anemia with accuracy, and to judge the effect of therapy (Table 2).

In the very mild iron-deficiency anemias which do not present the characteristic alterations of red cell morphology, and in obscure types of anemias, more detailed studies may have to be made. Serum iron values, iron-binding capacity determinations, and bone marrow aspirations examined for stainable hemosiderin granules are the most important of many tests which may be done to establish

TABLE 1—*Factors Responsible For Iron-Deficiency Anemia*

A. Chronic blood loss
   1. Peptic ulcer
   2. Malignant lesions of the stomach and bowel
   3. Hiatal hernia
   4. Esophageal varices
   5. Ulcerative colitis
   6. Meckel's diverticulum
   7. Jejunal diverticulae
   8. Gastritis
   9. Recurrent, severe epistaxis
   10. Repeated hemoptysis
   11. Bleeding hemorrhoids
   12. Uterine fibromyomata and carcinoma
   13. All other causes of menorrhagia and metrorrhagia must be considered too
   14. Microhematuria and macrohematuria
B. Defective absorption of iron
   1. Following extensive bowel surgery
   2. Achlorhydria
C. Inadequate dietary iron intake
D. Pregnancy
   1. Due to fetal demands for iron in a woman with depleted iron reserves

TABLE 2—*Laboratory Diagnosis in Iron-Deficiency Anemia*

IN THE AVERAGE CASE:
- Hemoglobin (colorimetric) in grams
- Hematocrit
- Red cell count
- Blood smear
- Mean corpuscular volume (MCV)
- Mean corpuscular hemoglobin (MCH)
- Mean corpuscular hemoglobin concentration (MCHC)

IN THE OBSCURE CASE:
- Serum iron values
- Iron binding capacity
- Bone marrow aspirations examined for stainable hemosiderin granules

the diagnosis. The outline in Table 3 is particularly useful when dealing with an obscure anemia.

Hemoglobinometry

The Talquist scale or similar color charts and the Dare hemoglobinometer, even the improved model, may give readings that vary from 10 to 40%. The many hemoglobinometers which use modifications of the acid hematin method, such as Salhi, Spencer, Hellige, Haden-Hauser, to name a few, are also subject to serious error. The sources of error (Table 4) are fading hematin standards, the innate difficulty most persons have in matching brown color, the error of visual acuity, abnormalities in color vision, inequalities in the technicians' training, fatigue and bias. The general method of determining hemoglobin on the basis of color or the brown color of acid hematin is not satisfactory even if the tests are simpler, quicker and easier to do. The photoelectric colorimeter is reliable and accurate for the estimation of hemoglobin. But even this method requires repeated standardizations of the apparatus against blood samples whose hemoglobin content has been determined by the oxygen capacity or quantitative iron determination.[1]

TABLE 3—*Study of Obscure Anemias*

I. History
- A. Bleeding from
  1. Alimentary tract
  2. Respiratory tract
  3. Vaginal tract
  4. Genitourinary tract
  5. Thrombocytopenic and simple purpura
- B. Malnutrition and/or avitaminosis
- C. Toxic processes
  1. External
     a. Lead contact
     b. Benzol, in dry cleaning and manufacturing
     c. Mercury
     d. Arsenicals
  2. Internal
     a. Infections
     b. Parasitic infections
- D. Endocrine disturbances
  1. "Masked" hypothyroidism
  2. Frank myxedema

II. Complete Physical Examination

III. Laboratory Workup
- A. Complete blood count, mean cell indices, hematocrit and hemoglobin
- B. Sedimentation rate or C-reactive protein test
- C. Reticulocyte response
- D. Tests for bleeding tendencies
  1. Ivy bleeding time
  2. Rumple-Leed test
  3. Coagulation time
  4. Clot retraction time
  5. Blood platelet count
  6. Prothrombin time
  7. Prothrombin consumption test
- E. Bone marrow study
- F. Urinalysis—gross and microscopic
- G. Basal metabolic rate (BMR) and/or protein-bound iodine (PBI) test
- H. Gastric Analysis
- I. Stool examination for occult blood and parasites
- J. Sigmoidoscopy
- K. Possible x-ray procedures
  1. Chest x-rays
  2. Gastrointestinal and barium enema
  3. Hysterography

TABLE 4—*Sources of Error in the Acid Hematin Method of Hemoglobinometry*

1. Fading hematin standards
2. Innate difficulty in matching brown colors
3. Errors in visual acuity
4. Abnormalities in color vision
5. Inequalities in technician's training
6. Fatigue and bias

TABLE 5—*To Eliminate Sources of Error In Hematocrit Determinations*

1. Use clean, dry glassware.
2. Draw blood from a vein without the use of a tourniquet after the needle has been inserted.
3. Use an anticoagulant mixture of ammonium and potassium oxalate as it prevents shrinkage of cells.
4. Be sure to fill the tube from below.
5. Remove all air bubbles at the top.
6. Centrifuge correctly for sufficient time and with the proper apparatus.

Hematocrit

The introduction of the hematocrit determination added an effective method for the estimation of red-cell mass and is quite suitable for office use. A great variety of tubes and technics has been devised for this test. The method of Wintrobe is advantageous since the erythrocyte sedimentation test can be run in the same tube before using it for the hematocrit determination. This combined technic also facilitates correction of the variation of sedimentation rate according to the volume of packed cells.

Other common sources of error (Table 5) must be watched for and eliminated. It is necessary to use clean, dry glassware; to draw blood from a vein without the use of a tourniquet after the needle has been inserted; to use as an anticoagulant a mixture of ammonium and potassium oxalate which prevents shrinkage of the cells; to fill the tube from below; to remove all air-bubbles at the top; and to centrifuge correctly. This last matter is of extreme importance in order to eliminate serious error. Since many clinical centrifuges now in use give a speed of 3,000 R.P.M. (whereas the required relative centrifugal force is 2,250 R.P.M.), it is suggested that instruments used for this purpose be properly calibrated.

Mean Cell Indices

The concentration of hemoglobin may be expressed by various indices. The color index (CI) has been used extensively in the past.

This is the average amount of hemoglobin in each erythrocyte compared to the average amount of hemoglobin in the normal erythrocyte. The index, although useful at times, lacks absolute value since it is based on arbitrary standards. Others have emphasized the importance of the size and number of erythrocytes in relation to the hemoglobin content. This work led to the determination and use of the volume index (VI) and the saturation index (SI). Studies finally led to the formation of indices designated as mean corpuscular hemoglobin (MCH) which is the average amount by weight of hemoglobin in the red cell; the mean corpuscular volume (MCV) which is the average size or volume of the red cells; and the mean corpuscular hemoglobin concentration (MCHC) which is the amount of hemoglobin in relation to the amount the cells could contain.

These indices may be obtained through mathematical formulas (Table 6) after the determinations for hematocrit, red cell count, and the hemoglobin content have been made. These newer determinations are found to have increasing usefulness in the study, classification, and diagnosis of the various anemias (Table 7) and to serve as checks on the usual red cell count, hemoglobin determination and examination.

Red Cell Count

All pipettes, hemocytometers, and cover slips should be accurate within the limits specified by the United States Bureau of Standards. The expense is greater in a small laboratory using this equipment. However, the cost is justified because of the greater accuracy of determinations. The inherent inaccuracies and unreliability of inferior laboratory equipment can never be justified on the basis of cost alone. Pipettes with broken tips are inaccurate and should not be used, and cover slips of inferior grade may be so defective as to lead to gross error.

Blood Smears

Strict adherence to technic and the use of a Wright's stain which has been allowed to "ripen" will reward the technician with a smear which offers clear information. Since Wright's stain improves with age, it is advantageous to keep a supply as long as possible. Keep a large bottle on the shelf "ripening."

On hypochromic (iron-deficiency) anemias the cells appear pale and washed out, and in the more severe cases there may be a mere ring of color. In hyperchromic anemias the red cells stain more heavily than normal and lack the paler centers of the hypochromic cell. Under some conditions the red cells stain with a diffuse bluish cast known as polychromatophilia or polychromasia. This suggests the active response of bone marrow regeneration, as does anisocytosis.

TABLE 6—*Blood Indices*

Mean Corpuscular Volume (normal, 80 to 94 cu. microns per cell; average, 87 cu. microns)

$$MCV = \frac{\text{hematocrit (per cent) x 10}}{\text{erythrocyte count } (10^6/\text{mm.}^3)}$$

Mean Corpuscular Hemoglobin (normal, 27 to 32 micromicrograms per cell; average, 27.5 micromicrograms)

$$MCH = \frac{\text{hemoglobin [(gm./100 ml.) x 10]}}{\text{erythrocyte count } (10^6/\text{mm.}^3)}$$

Mean Corpuscular Hemoglobin Concentration (normal, 33 to 38% per 100 ml. of packed red cells; average, 35%.)

$$MCHC = \frac{\text{hemoglobin (gm./100 ml.)}}{\text{hematocrit per cent}} \times 100$$

TABLE 7—*Characteristic Values in Four Types of Anemia*

Type of anemia	MCV	MCH	MCHC
Microcytic	50– 71	22–26	31–38
Normocytic	80– 94	27–32	33–38
Macrocytic	95–160	30–52	31–38
Hypochromic		14–21	21–29

Iron-Loading Test

Recently many investigators have used Jasinski's oral iron tolerance test[3] as a method of determining the presence of iron-deficiency anemia. Here a dose of ferrous gluconate containing approximately 165 mg. of elemental iron is given to the fasting patient. Plasma iron determinations are made before the oral dose of iron and at one, three, and usually seven hours after. Jasinski asserts that a large rise in plasma iron proves iron depletion. However, he has not established clearcut standards for the interpretation of his curves. Beutler has been unable to find any acceptable evidence that the iron tolerance curve is a valid means of assessing the iron stores, even though it has been used extensively for this purpose. Because of his experience with it, he believes it to be a worthless test. The contour of the iron tolerance curve undoubtedly depends on factors that are completely independent of storage iron.

Treatment

Assuming that all serious cause of an iron-deficiency anemia has been eliminated, one can proceed with the symptomatic treatment.

Iron-deficiency anemia is treated by the administration of iron in quantities that are adequate, and in a form that is well tolerated and utilizable by the patient. Oral administration is the preferred route in all but a very small percentage of patients, and ferrous salts the preferred form. This is an effective inexpensive therapy. However, it must be realized that while blood values rapidly return to normal and the anemia disappears on this therapy, the tissue-iron stores are restored to normal only after many months of continuous treatment.

According to Hagedorn[5] parenteral iron therapy is rarely necessary. One must remember that since practically no iron is lost from the body once it enters the tissues, except through blood loss, the parenteral administration of excessive amounts of iron over long periods of time will lead to tremendous iron concentrations in the body and can possibly cause diffuse tissue injury such as exogenous hemochromatosis. Iron administration is not therefore without risk of untoward reactions.[6-8]

Let us not be led into a false sense of security by the ease of administration of ferrous compounds. A new clinical entity, acute iron intoxication, has been described,[9-12] and it behooves us to use iron preparations more judiciously than we may have in the past.

Adequate absorption of iron for the treatment of iron-deficiency anemia has always been a problem. The large doses of ferrous sulfate required to produce a therapeutic effect are poorly tolerated in about one-third of the patients treated. Therefore we are constantly searching for iron preparations that are more readily absorbed. These will permit the use of smaller doses and thereby eliminate toxic side-effects. My experience with two such preparations[13,14] was that although they were better than most iron preparations at the time, I was still not satisfied they were the ideal drugs for the purpose.

In the course of toxicity studies with polyoxyethylene sorbitan monolaurate, a surface-active agent, Wissler and his associates[18] observed that the prior intake of this wetting agent increases the gastrointestinal absorption of radio-iron in the golden hamster. Krantz and associates[19] demonstrated the safety of polyol monolaurate even when administered for prolonged periods. By adding 90.9 mg. of ferrous gluconate (representing 10 mg. of elemental iron) and 100 mg. of polyoxyethylene glucitan monolaurate (Sacagen) in a capsule (Simron) and using an average dosage of three capsules a day given between meals and at bedtime, I observed[15] that an average of 28.8% of the iron in the capsule could be accounted for by the iron in the increased amount of circulating hemoglobin. Others have reported as little as 1.3% incorporation into circulating hemoglobin for reduced iron[16] and an average of 2.5% for an iron salt.[17]

The lack of side-effects during the administration of this compound was of particular interest as there was hardly enough unabsorbed iron left in the gastrointestinal tract to color the stool. On the basis of these preliminary studies, it appears that the simultaneous administration of polyoxyethylene glucitan monolaurate and iron gluconate makes it possible to reduce the dosage of iron to about one-third of the previously used amount with the same degree of response.

Summary

There is no justification in characterizing iron-deficiency anemia as an idiopathic condition. It is our obligation to find the cause of the anemia if possible, so that there will be no delay in definitive therapy. By strict adherence to meticulous laboratory technics an accurate diagnosis of iron-deficiency anemia can be made. Treatment should be with an iron preparation that is well tolerated, well absorbed, relatively free from side-effects, and highly effective. Treatment should be continued for a period after the hemogram returns to normal so as to allow for replenishment.

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The Diagnostic Evaluation of the Infertile Couple

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THE PROBLEM of infertility is of grave concern to those couples who seek the aid of their physician because of a barren marriage. The degree of natural frustration and anxiety experienced by these couples is tremendous and often begins to develop within six months of marriage.

Approximately 12% of marriages are estimated to be involuntarily sterile.[1] Fertility is a relative state of being, and the lack of it is apparently dependent upon multiple factors.[2,3] Relative infertility may be said to exist when six months of marriage without contraception has not resulted in pregnancy.[1]

Success in managing these problems is related to thoroughness and interest on the part of both physician and patient. The following outline and brief discussion are suggested as a guide to the study of the infertile couple.

Diagnostic Study of the Infertile Couple

I. For Both Husband and Wife[4,5]

A. Family History (not usually considered significant)

B. Previous Medical History
1. Mumps, scarlet fever, or recurrent tonsillitis.
2. General health during premenstrual and adolescent periods.
3. History of overwork, chronic mental or physical strain, malnutrition, and/or anemia.
4. Venereal disease should be asked for by name and by symptomatology as well as post-abortal or post-partum pelvic inflammatory disease (salpingitis, epididymitis).
5. History of weight, past and present.

C. Marital History
1. Separate histories regarding previous marriage and/or pregnancy (and its outcome).
2. History of frequency of intercourse, libido, potency, completeness of penetration, dyspareunia, and wife's experience of orgasm.
3. History regarding posture during and after intercourse, remaining supine and avoiding douching or tampax after intercourse.
4. Duration of involuntary and voluntary sterility.

D. History of Mode of Life
1. History of dietary habits, rest, recreation, vitality, exercise and emotional stress.
2. Use of drugs, alcohol and tobacco.
3. Does husband use long, hot tub baths?
4. History of exposure to radiation.

E. Emotional Status (history should be obtained gradually, subtly and unobtrusively)
1. Is there evidence of anxiety or over-conscientiousness?
2. Attitude toward motherhood, pregnancy and delivery.
3. Emotional relationships between husband and wife.
4. Wife's attitude toward outside work and housework.
5. Wife's attitude toward mother and father (comparison of husband with patient's father, and wife's ideas of motherhood and marriage as compared to her mother's ideas).
6. Is the wife's desire for pregnancy out of proportion to the problem at hand?

From the Department of Obstetrics and Gynecology, Marquette University School of Medicine and the Department of Obstetrics and Gynecology, St. Luke's Hospital, Milwaukee, Wisconsin.

F. Surgical History of the Husband
   1. Surgery for hydrocele, varicocele, hernia.
   2. Surgery for cryptorchism (age when performed).[5]
   3. History of prostatic disease.

G. Surgical History of the Wife
   1. Surgery for tubal occlusion.
   2. Acute appendicitis or salpingitis or diverticulitis.
   3. Ectopic pregnancy.
   4. Any ovarian or uterine or cervical surgery or cautery.

H. Menstrual and Vaginal History
   1. Onset of menses.
   2. Regularity of menses (duration, interval, amount).
   3. Dysmenorrhea.
   4. Change in menstrual pattern after marriage.
   5. Mittelschmerz, if present.
   6. Midcycle spotting, if present.
   7. History of past menstrual irregularities.
   8. History of cervicitis, vaginitis, vulvitis, or infection of Skene's or Bartholin's glands.
   9. Presence of vaginal discharge (symptoms, amount, odor and quality, when present).

I. History of any pertinent tests done previously (transcripts of these as well as operative records should be obtained)

II. Special Tests on the Husband
   A. Complete Physical and Urological Examination
   B. Wassermann Test
   C. Complete Blood Count
   D. Complete Blood Typing
   E. Protein-bound Iodine Determination (basal metabolic rate and serum cholesterol determination, only if they seem to be indicated)
   F. Urinalysis
   G. Complete sperm analysis[6,7]
      1. Volume (2–5 cc.).
      2. Turbidity.
      3. Viscosity.
      4. Number of sperm per cc.
         (a) Normospermia:
             60 million/cc.
             60–80% motile
             ½ to 1 hour after ejaculation
         (b) Hypospermia:
             25–60 million/cc.
             40–60% motile
         (c) Oligospermia:
             25 million/cc.
             40% motile
         (d) Sterile:
             No sperm
      5. Morphology (80% oval forms).
      6. Motility (see 4 a, b, and c above).
   H. Additional Tests for the Infertile Husband
      1. Testicular biopsy when indicated.
      2. X-ray of the skull when indicated.
      3. Glucose tolerance test when indicated.
      4. Hormonal biologic assays for the occasional case.

III. Pertinent Factors in Male Infertility

The figures given above indicate values of sperm count and motility and their classification. Most investigators are inclined to believe that sperm motility is more important than the actual count.[8–11] The probability of conception resulting from a single unprotected coitus in the population at large has been reported as being 1 in 50 and 1 in 25.[10] In regard to normal fertility the results obtained with artificial insemination are informative. Fifty per cent of patients treated by artificial insemination usually become pregnant in three months and 90% in six months.[12–14]

As noted above absolute male sterility is defined only as a total absence of sperm. Nineteen per cent of women with a positive Simms–Huhner test can become pregnant when the husband's total sperm count is in the range of 1 to 20 million per cc.[14]

Many of the metabolic tests such as glucose tolerance test and protein-bound iodine determination as well as x-rays of the skull and endocrine studies are intended for those with some deficiency in their sperm analysis. When metabolic deficiencies are found, their correction may be all that is required. There is, for instance, no serious disturbance in spermatogenesis in controlled diabetic patients.[15]

In male patients with seriously deficient sperm counts, an effort should be made to improve the count. The diet

should be improved. In animals, diets which are deficient in calories, fat, vitamin E, and protein impair testicular function.[15] The amino acid, arginine, has been shown to be essential in man.[16] Weight problems, diet, rest, activities, use of alcohol and tobacco, must be adjusted. In these patients abstinence prior to the fertile period should be exercised, although not to the extent that it could conceivably impinge upon the fertile period. The value of abstinence in increasing the count is controversial.

It has been shown that there is a greater number of more active sperm present in less than 50% of the ejaculate, usually the first part.[16] Various methods have been devised for concentrating seminal fluid.[16] These considerations are only of interest if one is planning intra-cervical or intra-uterine insemination. (See below for mention of homologous insemination of semen collected after intercourse and processing.) Even though intra-uterine insemination is practiced widely in veterinary medicine, most gynecologists are opposed to its use. There is real danger of introducing infection; and if we cannot help, we must not run the risk of doing harm.[17]

There are several methods of hormonal therapy for serious male sperm deficiencies. Human chorionic gonadotropin has been given to desensitize the sex center to endogenous sex hormone, resulting in over-production effect which supersedes the rebound phenomenon.[18] The use of testosterone or similar hormones to obtain the rebound phenomenon is well recognized.

In male patients with seriously deficient sperm motility (under 60% motile forms), it is of interest to know what can be done to improve this defect.[19] Ovulatory cervical mucus has been reported to increase deficient sperm motility.[20] The seminal plasma of normal human semen has been reported to stimulate the motility of spermatozoa of low motility from oligospermic semen.[21] The washing of immotile sperm in blood plasma has also been reported to restore motility.[22]

It is in patients whose husbands have deficient counts that the exact time of ovulation becomes important. (See ovulation below.) In these patients, in addition to specific therapy, intercourse twice within a period of six to eight hours at the time of ovulation should give as good results as those obtainable from homologous insemination. If because of low motility any treatment of sperm is contemplated, this can be accomplished by collecting sperm after intercourse, using methods totally acceptable to all religious groups, and inseminating with a cervical cap. This form of insemination gives as good results as any known.[23]

IV. Special Tests on Wife

A. Complete Physical Examination

B. Complete Gynecologic Examination

1. Papanicolaou smear.
2. Hanging drop of vaginal secretions for Trichomonas and Candida.

C. Complete Blood Count

D. Wassermann Test

E. Complete Blood Typing (including Rh factor)

The evidence seems to indicate that heterospecific matings where the husband carries an ABO (H) antigen on his erythrocytes, which is not present on the wife's can create a situation where her antibodies may act as hemolysins or hemagglutinins to his erythrocytes. Previous studies have demonstrated that the ABO antibodies occur in cervical secretions and that antigens are carried on spermatozoa. A concept of infertility has thus been postulated based on agglutination of sperm by the cervical secretions in incompatible ABO matings.[24]

F. Protein-bound Iodine Determination (basal metabolic rate and serum cholesterol determination, only if they seem indicated)

The consensus is against the empirical use of thyroid hormone in the infertile patient or habitual aborter unless there is laboratory evidence of thyroid deficiency.[25,26] There are many contrary opinions.[27,28]

G. Urinalysis

H. Sedimentation Rate for Occult Infection

I. Chest X-ray

J. Pregnenediol Determinations at the Height of Corpus Luteum Function

Probably this would rarely be indicated, although more often in habitual abortion than primary infertility. It could have value where luteal phase endometrial biopsy was equivocal regarding luteal phase adequacy.[29,30]

K. Tubal Examination

1. Rubin test with carbon dioxide is positive with low abdominal auscultation and shoulder pain.

If either of two signs of patency are absent, the test should be repeated after sedation and antispasmodics. When combining procedures, the Rubin test should precede any other manipulations in order to preclude possible embolism and to avoid inducing tubal spasm by other procedures.[31] It is generally recommended that the best time for the Rubin test is one week after cessation of the menses.[32]

2. Hysterosalpingography.

While many utilize hysterosalpingography as an initial test for tubal patency, we prefer to reserve it for occasions when the Rubin test is negative or doubtful. It is the opinion of I. C. Rubin that tubal insufflation should precede hysterosalpingography because thereby the latter may be unnecessary.[31]

L. Endometrial Biopsy

This important test is necessary to absolutely confirm ovulation. It is the most practical method of detecting inadequate luteal phase in those who are ovulating and in diagnosing endometritis. It is to be noted that patients with prolonged dysfunctional uterine bleeding will have leukocytes in the specimen so that the pathologic report will usually read "endometritis." Endometrial biopsy done on the first day of menstruation, as recommended by Emil Novak, will allow the diagnosis of ovulation. A biopsy at this time, however, is relatively useless for diagnosing adequate luteal phase endometrial response. For this reason most investigators suggest abstinence during the cycle in which the biopsy is to be taken and biopsy on the 26th day of the 28-day cycle.[4–6, 33]

M. Simms–Huhner Test

Almost all investigators consider this test of great importance.[34,35] Cervical mucus is examined 2 to 12 hours after intercourse for the presence of and condition of the sperm it contains. Specimens are taken from the vaginal pool, the lower cervix and upper cervix and each is evaluated separately. The specimens should be examined first without a cover slip, since the cover slip decreases motility,[34] and then counted with the cover slip for the number of sperm per high-power field. Normally 10 to 15 active spermatozoa can be seen per high-power field. The timing of the test after intercourse should be standardized; after sampling the vaginal pool, the cervix should be wiped dry and cervical sampling must be atraumatic (blood cells have an adverse effect on sperm motility). The examination should be performed from the 10th to the 14th day of the menstrual cycle when cervical mucus is most receptive.[11,34] At the time of the Simms–Huhner test the spinnbarkeit of the cervical mucus (8–10 cm.) and number of bacteria per high-power field can be recorded.

One negative Simms–Huhner test is not conclusive and the test must be consistently negative. Negative tests could possibly be checked by a sperm penetration test.[36]

When the Simms–Huhner test is negative from the vaginal pool suggesting a "hostile vagina," the patient may be treated with "Nutri-Discs" or similar alkaline nutrient douche prior to coitus.

"Cervical hostility" directs attention to cervicitis, physical evaluation of cervical mucus, and a search for

blood type or other semen-mucous incompatibility.

It has been suggested that when the fern test (see below) is positive and the Simms–Huhner test is negative, the defect is not that of simply faulty cervical mucus or other cervical factors.[36]

N. Arborization of Cervical Mucus

Cervical mucus aspirated and allowed to dry for 24 hours on a clean glass slide will in the normal cycle show the following picture: Up to the 8th day of the cycle there will be no arborization (fern pattern). From the 8th to the 22nd day (peak at 12th to 16th day) there will be spinnbarkeit and arborization, and after the 22nd day there will be no arborization. Minimal arborization indicates either progestational activity or an absence of estrogen. Full arborization indicates low progesterone.[5,37] This can be helpful in evaluating ovulation and in the prediction of abortion.[37]

O. Colpocytogram and Cornification Index

These vaginal smears taken during the cycle have been reported by some to be of value in timing ovulation and in the evaluation of estrogenic activity.[38]

P. Glucose Testing Tape for Timing Ovulation[39,40]

The complete reliability of this method has yet to be determined. The most reliable product at this writing appears to be "Tes-Tape." It would be a simple matter to include this test along with the temperature chart.

Q. Temperature Chart[41]

This constitutes one of the best known and most reliable methods of determining whether ovulation is made and its time in the cycle. It should be taken under standard conditions and correlated with the "Tes-Tape" test as well as with arborization, endometrial biopsies, and menstrual pattern. Ovulation is believed to occur just before the rise in temperature. It is particularly important to have an idea of the exact time of ovulation when the husband has a deficient sperm pattern. In most cases after three to four months, when a more exact knowledge of the most fertile period has been obtained, the temperature chart should be discontinued as the procedures involved tend to increase tension during the fertile period. In addition, temperature chart studies may indicate a latent undiagnosed endometriosis as a cause of sterility. Many of the patients have pyrexia at the time of menstruation.[42] In addition the temperature chart can be helpful in the diagnosis and management of anovulatory functional uterine bleeding and in the diagnosis of amenorrhea due to traumatic endometrial sclerosis.

R. Management of Ovarian Endocrine Infertility

1. Follicular phase defect.

In unselected infertility cases approximately 9% are anovulatory.[1] An inadequate follicular phase is characterized by a prolonged menstrual interval or a failure of ovulation. Consistent failure of ovulation with a regular 28-day cycle is rare; cervical dysfunction is a follicular phase defect.[1] These cases often constitute the most difficult to manage successfully. Treatment consists of general regulation of hygiene with additional thyroid therapy when indicated. Cyclic hormone therapy with estrogen and progesterone may be tried and will prove most efficacious in those patients with dysfunctional uterine bleeding. Some have reported the induction of ovulation in the human by means of an "estrogenic flood."[43] Considerable success has been reported with low dosage cortisone therapy.[1,44] Mild adrenal dysfunction may benefit whether or not the urinary 17-ketosteroid excretion is increased. Patients who are obviously suffering from Stein–Leventhal syndrome, a group of symptoms and findings

characterized by amenorrhea and/or abnormal uterine bleeding, should be offered surgical ovarian wedge resection.

2. Luteal phase defects.

This is the most common endocrine abnormality (50%) in infertility patients.[1] The diagnosis is made by endometrial biopsy and confirmed by urinary pregnanediol studies. General hygienic therapy is important in these patients. Specific therapy consists of exogenous progesterone, starting four days after the basal temperature chart shows a rise and continuing until menstruation occurs (or pregnancy ensues) and the pregnanediol output is adequate. It is to be emphasized that failure of ovulation is a follicular phase defect and not a luteal phase defect.

V. It Must Never Be Forgotten That Fertility is a Most Serious Problem

For this reason these patients must not be denied anything that might conceivably be of help to them. Similarly we must do nothing to these patients which might make their situation worse. Because of this, we believe adoption proceedings should be offered to these couples as soon as they have their basic infertility investigation. They can still continue in a planned and deliberate program taliored to their needs.

Summary

An outline for the diagnostic evaluation of the infertile couple is presented along with a brief discussion on the utilization of some of the investigations.

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The Prevention of Perinatal Deaths

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FOR MANY YEARS public health workers have used fetal deaths (fetuses stillborn after 20 weeks gestation) and infant deaths during the first week (hebdomadal deaths) or month of life (neonatal deaths) as yardsticks for measuring the effectiveness of their programs. These were measures of what was happening before, then during and after, the birth process. In recent years it was realized that we should be considering the whole birth process, and as a result, a new statistic was developed to study this period. This is the perinatal mortality rate which focuses attention on the casualties occurring from conception to a period after delivery.

At first many different methods were used to calculate this rate, and considerable confusion resulted. In 1959 the committee on Maternal and Child Care of the Council of Medical Services of the American Medical Association published *A Guide for the Study of Perinatal Mortality and Morbidity* which brought order out of the chaos. Two perinatal periods were proposed:

"1. Perinatal Period I as a minimum basis for achieving nationwide, as well as international comparability, will begin with deaths of fetuses weighing 1,001 grams (28 weeks gestation) and include deaths of infants occurring in the first seven days of life (hebdomadal period).

"2. Perinatal Period II for more inclusive study, and recommended whenever and wherever possible, will begin with deaths of fetuses weighing 501 grams or more (20 weeks gestation) and include deaths of infants occurring in the first 28 days of life (full neonatal period)."[1]

A perinatal mortality rate can be calculated for each period as follows:

1. Perinatal Period I rate is calculated by the following formula:

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TABLE 1—*Live Births, Fetal and Neonatal Deaths and Perinatal II Mortality Rate Wisconsin 1950–59 (Resident Figures)*

Year	Live Births	Fetal Deaths		Neonatal Deaths		Perinatal II
	Number	Number	Rate*	Number	Rate**	Mortality Rate***
1950	82,364	1,241	15.1	1,571	19.1	33.6
1951	87,819	1,343	15.3	1,647	18.8	33.5
1952	88,941	1,267	14.2	1,606	18.1	31.8
1953	88,408	1,251	14.2	1,508	17.1	30.8
1954	91,570	1,216	13.3	1,482	16.2	29.1
1955	92,333	1,233	13.4	1,670	18.1	31.0
1956	93,496	1,235	13.2	1,605	17.2	30.0
1957	96,398	1,278	13.3	1,601	16.6	29.5
1958	95,950	1,246	13.0	1,670	17.4	30.0
1959	98,518	1,222	12.4	1,728	17.5	29.6
Total	915,797	12,532	13.7	16,088	17.6	30.8

*Fetal deaths—20 weeks gestation or more per 1,000 livebirths.
**Infant deaths—in first 28 days of life per 1,000 livebirths.
***Fetal deaths—20 weeks gestation or more and infant deaths first 28 days of life per 1,000 livebirths plus fetal deaths 20 weeks or more.
Source: Public Health Statistics, Wisconsin State Board of Health.

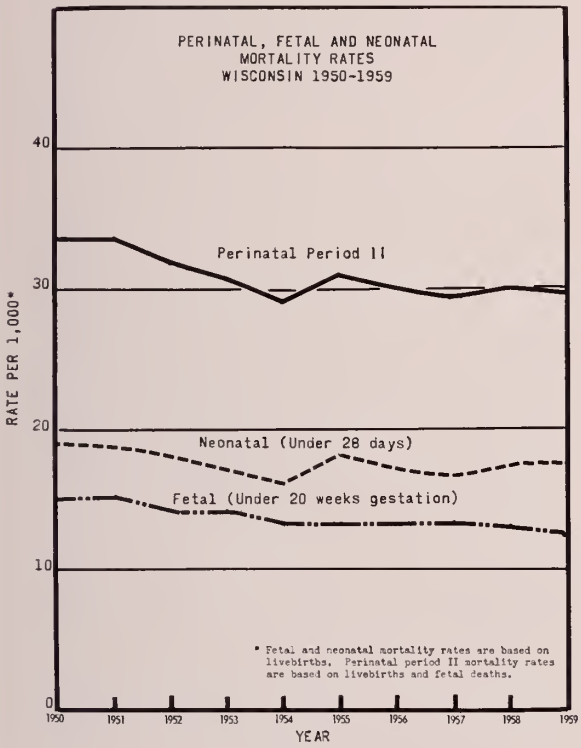

Figure 1

$$\frac{\text{Hebdomadal deaths plus fetal deaths 28 weeks gestation and over}}{\text{Pregnancies (live births plus fetal deaths) 28 weeks gestation and over}} \times 1{,}000$$

2. Perinatal Period II rate is calculated by the following formula:

$$\frac{\text{Neonatal deaths plus fetal deaths 20 weeks gestation and over}}{\text{Pregnancies (live births plus fetal deaths) 20 weeks gestation and over}} \times 1{,}000$$

Beginning with the data for 1960, the Wisconsin State Board of Health will publish information concerning both rates. However, data for the calculation of the Perinatal Period I mortality rate, while available for prior years, has not been tabulated. Table 1 gives the data necessary for calculation of the Period II rate for the past decade and the graph (Fig. 1) shows the fetal, neonatal, and perinatal rates for the same period.

From the graph it can be seen that the perinatal and neonatal rates follow the same pattern. There is a rather marked decline during the first half of the decade and then a levelling off, with the rate fluctuating around a fixed point, 30 for the perinatal

TABLE 2—*Leading Causes Infant Deaths—Under 28 Days—Wisconsin 1955–59*

Cause	ILN	1955		1956		1957		1958		1959		5-Year Total	
		No.	% All Causes	No.	% All Causes	No.	% All Causes	No.	% All Causes	No.	% All Causes	No.	% All Causes
All Causes		1,674	100	1,617	100	1,606	100	1,696	100	1,728	100	8,321	100
Immaturity, unqualified	776	493	29.5	512	31.7	454	28.3	457	26.9	433	25.1	2,349	28.2
Postnatal asphyxia, etc.	762	290	17.3	263	16.3	279	17.4	292	17.2	298	17.2	1,422	17.1
Birth injury	760, 761	324	19.4	257	15.9	260	16.2	305	18.0	276	16.0	1,422	17.1
Congenital malformations of circulatory system	754	108	6.5	91	5.6	97	6.0	116	6.8	92	5.3	504	6.1
Hemolytic disease	770	65	3.9	62	3.8	71	4.4	62	3.7	69	4.0	329	4.0

Source: N.O.V.S. Annual Reports.

rate and 17 for the neonatal. The fetal rate shows a gradual, though slight, decline throughout the decade. It is obvious then that it is the neonatal deaths that are keeping the rate up.

What are the causes of these neonatal deaths? Table 2 lists the leading causes of deaths of infants under 28 days of life by year for the past five years. During this period, these five causes were responsible for about 72% of all neonatal deaths (Table 2).

Of the five, the three most important are immaturity, postnatal asphyxia and atelectasis, and birth injuries, which account for over 60% of all deaths in this age group.

What can be done to reduce the deaths from these causes? Nesbitt[2] in discussing the prevention of perinatal casualties lists six major steps or factors to be considered:

1. Solution of the problem is the joint responsibility of several health disciplines including obstetrics, pediatrics, anesthesiology, nursing, hospital administration, and public health—the entire community and all its medical workers.
2. There should be a wider application of what is now known about patient care.
3. Elevation of living standards among the underprivileged classes is necessary since low standards of obstetric care, low standards of living, and ignorance go hand in hand.
4. Preconceptional care of patients must be improved since a successful outcome of a pregnancy depends in large measure upon the patient's general medical status when conception occurs.
5. Expanded and improved professional and lay education is necessary.
6. There should be developed a clinical attitude in obstetrics which emphasizes conservative technics of management.

The reduction of perinatal mortality in premature infants primarily involves obstetric considerations for, with few exceptions, the longer the fetus can remain in the uterus the better are its chances for extra-uterine survival. This does not mean that good pediatric care is not important, for once a child is born prematurely, proper care is essential. It is our philosophy in Wisconsin that such care can best be given in the hospital where the child is born, and to that end the indoctrination and training of teams of physician and nurses in the care of prematures should be undertaken by all hospitals no matter how small.

We have discussed the concept of perinatal mortality rates, the course they have taken in Wisconsin in the past five years, the causes behind the rates and some proposed solutions to the problem. If each of us does his share we will soon begin to see a reduction in the number of lives lost needlessly during this dangerous period of development.

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AERODYNAMICS OF RESPIRATION

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Abstract from *Annals of Allergy* 18:881 (Aug.) 1960.

In patients with extensive pulmonary disease, the work of breathing may be increased to such an extent that most of their energy is expended for ventilation alone, thus depriving them of that energy necessary for additional physical exertion, and to maintain adequate cerebral activity.

Four features are found in patients with bronchial asthma:

1. Edematous engorgement and sub-epithelial thickening of the bronchi and their branches.
2. Accumulations of thick, tenacious mucus and pus.
3. Spasm of smooth muscles of the bronchioles.
4. Peribronchial pressure greater than intraluminal pressure resulting in collapse of bronchioles and excessive air-trapping.

Alveolar hypoventilation arising out of a disturbed ratio between air flow and blood flow results in an increase in the alveolar-arterial oxygen difference, unless a compensatory vasoconstriction occurs.

On the other hand, alveolar hyperventilation, unless compensated by increase in capillary flow, leads to an increased work load because of the additional physiologic dead space created.

These functional disturbances lead to hypoxic alveolar-respiratory insufficiency and eventually causes the dreaded triumvirate of pulmonary emphysema, respiratory acidosis and cor pulmonale.

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COMMENTS ON TREATMENT

The Antihypertensive Effects of the Benzothiadiazine (Thiazide) Diuretics

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THE DIURETIC value of the benzothiadiazine derivatives, of which chlorothiazide (Diuril) is the prototype, is well established. The reported salutary effects of this compound and more recently introduced surrogates in the symptomatic therapy of hypertension recommends a consideration of some of the pertinent facts relating to their use in this condition.

The first report describing the effects of chlorothiazide in hypertensive patients was that of Wilkins[1] in November, 1957. Since that time five derivatives have been placed on the market and evaluated, to a greater or lesser extent, in hypertensives. Recently, a sixth, polythiazide, has been shown to be capable of lowering the blood pressure in individuals with hypertension.[2] There certainly is no doubt about the existence of blood pressure lowering activity in the benzothiadiazine group of diuretics, but just what can be expected from these agents in relation to their long-term effectiveness in the treatment of hypertension? A partial answer can be realized by reference to a few of the more carefully controlled studies which have been of sufficiently long duration to allow one to make certain intelligent deductions and prognostications.

Wilkins[1] noted the hypotensive activity of chlorothiazide was enhanced by administration of ganglionic blocking agents. The many reports since have borne this out, and the use of both drugs in the treatment of certain hypertensives is well founded. (It is to be noted, however, that this does not imply the author would, in any sense, condone the use of these agents in fixed proportion in a single dosage form.) Finnerty and associates[3] evaluated the effectiveness of chlorothiazide administered as the sole agent and chlorothiazide in combination with reserpine and a ganglionic blocking agent, over a period of six months, in individuals with hypertension of varying severity. In severe hypertensives chlorothiazide alone or a combination of reserpine and a ganglionic blocking agent were ineffective in causing a significant reduction of mean blood pressure. Combination of the three drugs reversed the accelerated phase of the hypertension in all patients in this group. It also was found that in those patients with moderately severe hypertension chlorothiazide alone or hydralazine plus reserpine effectively reduced blood pressure in 50 per cent of the cases. Combining chlorothiazide with either of the latter agents produced satisfactory control of all patients. At that time, 1959, the authors suggested division of antihypertensive therapy into two phases: (1) Initial, (2) Maintenance. The type of treatment in the two phases would be dictated by the severity of the hypertension. Initial therapy recommended in the accelerated phase of hypertension was a ganglionic blocking agent plus a thiazide and reserpine. With control, substitution of veratrum or hydralazine (Apresoline) for the ganglionic blocking agent usually was accomplished without reduction in the benefits of antihypertensive therapy. In moderately severe hypertension the recommendation for initial treatment was the same as that for the maintenance phase of the severe type followed by deletion of veratrum or hydralazine after the reduced blood pressure had stabilized for two or three months. Perhaps one might have some reason for slight modification of the more specific recommendations of these regimens insofar as drug choice is concerned,

but the basic concepts of multiple attack and the employment of more potent agents in the severer forms of the disease are entirely logical.

Perhaps the question of possible difference in effectiveness of the various thiazides has arisen in the minds of some readers of this page. Complete assurance that such differences do not exist can not be given, but the work of Ford[4] suggests this probably is the case. Certainly, in equivalent dosage (doses determined to be minimally effective with respect to hypotensive action), substitution of hydroflumethiazide for chlorothiazide in hypertensive patients did not cause any significant change in blood pressure over a period of 24 weeks. Comparison of chlorothiazide with hydrochlorothiazide over a 3-month period also has failed to demonstrate that the more active thiazides offer any advantage over the less active ones either in terms of their antihypertensive effects or a lower incidence of side actions.[5]

Ford[4] has called attention to a point which this author has previously emphasized in a more general way. Therapy of hypertension must be individualized. Since, very often, treatment of this disease requires the use of more than one drug, i.e. a diuretic (commonly a thiazide), rauwolfia and a ganglionic blocking agent, it is important that the physician retain control over the dose of each to assure the patient of the maximum benefits derivable therefrom.

What can be expected from the long-term therapy of hypertension with the thiazides? Many studies of longer or shorter duration than these referred to previously could be cited to demonstrate the effectiveness of these drugs as hypotensive agents. However, all these are of relatively short duration in terms of the natural history of mild or moderate hypertension where the thiazides are most effective when used as the sole therapeutic agent. Consequently, it is impossible to supply the answer to the question of whether long-term prognosis of uncomplicated hypertension is improved by the modest, hypotensive effect produced by these drugs.

In conclusion a few remarks might be directed to the role the diuretic action of the thiazides may play in the hypotensive response which they produced. Wilkins[1] originally noted the antihypertensive action of chlorothiazide was related only partly to its diuretic effects. How much of a role, if any, the latter plays was not apparent until recently. Only this year Rubin *et al.*[6] have synthesized antihypertensive compounds of the benzothiadiazine series possessing no diuretic activity. I am certain we can expect more developments in this area.

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PRESIDENT'S PAGE

Who's That Knocking at Your Door?

ATOMIC MEDICINE, edited by Charles F. Behrens, M. D., Baltimore, in his preface speaks of "the atom (which) knocks at the doctor's door," and further, "the relentless tide of human events and scientific progress has engulfed the medical profession in a flood of problems, largely unfamiliar, related to the use of atomic energy."

The struggle for survival has ever been the lot of man. This is equally true whether one accepts our origin as a speck of protoplasm, cautiously extending a pseudoped, reaching for a tenuous grip on some rocky darkened shore or the theologists view that the breath of life was blown into man by our Creator. Since that day when our forbears were driven from the garden to face the ceaseless struggle from which only death can release us, we have fiercely resisted our earthly end.

Whether we are among those who refuse to believe there is anything beyond the confines of our globe or among those who affirm the possibility of eternal life through faith, we are one in our determination to postpone the moment of death.

Whether we are of one mind or the other, we have a responsibility to all mankind. Man has struggled too far over the countless centuries of time to permit the loosening of the bomb to send us back over that tortuous and laborious route.

But if mankind should foolishly permit the bomb to fall from the skies with its devastating effect on friend and foe alike, the medical profession must be prepared to assume leadership in the manner of protection offered and in repairing the ravages of the destructive effect.

Where will you take refuge when the bomb falls? What will you eat that day? Where will your children sleep that dark night? What answer will we give those suffering who hold us accountable for action or lack of action?

There are several approaches to this problem not the least of which is seeking means for physical security. Other thoughts on the subject of Civil Defense will be discussed in future issues.

We have been advised time and again to build a shelter from fall out in our homes. Let us do it, and encourage others in the same action. Our national leaders, governmental and military, fear the dangerous effect of a defeatist attitude of "what's the use?" Stock the shelter with food and water for two weeks, equip it for sleeping and living, provide for sanitation, and install necessary tools and instruments for measuring fall out.

We must hold on to the need and desire to always want to begin again. In his play about survival, "The Skin Of Our Teeth," Thornton Wilder tells us through Mr. Antrobus:

"Oh I've never forgotten for long at a time that living is struggle. I know that every good and excellent thing in the world stands moment by moment on the razor-edge of danger and must be fought for—whether it's a field or a home, or a country. All I ask is the chance to build new worlds and God has always given us that . . . And has given us voices to guide us; and the memory of our mistakes to warn us. We've come a long ways . . . We've learned—We're learning . . . and the steps of our journey are marked for us here."

Leigh H. Lockhart

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Crash Program

EACH HOLIDAY weekend the National Safety Council publishes a gloomy prediction of the death toll on the highways, and regularly as the arrival of Christmas, the predictions are either neared or exceeded by the actual statistics. A large volume of effort has gone into planning improved highways to reduce the hideous traffic fatalities; but as each year puts more and more automobiles on the highways and as speed limits creep upward, the odds against avoiding mishaps on the road plunge downward.

As cars have developed, certain improvements have become built-in. "Safety" glass in the windshield, positive door locks, padded dashboards, sun-visors, energy-absorbing steering wheels, and seat belts are among the safety features already incorporated in modern automotive designs. Yet accidents continue at great rate, and injuries to the occupants of automobiles constantly increase.

To combat this melancholy trend, the Council of the State Medical Society has agreed to participate in a study of the causes of injury and deaths in automobile accidents in Wisconsin. This project is sponsored by the Automotive Crash Injury Research of Cornell University and has the cooperation of the Wisconsin Highway Patrol of the Department of Motor Vehicles, the Wisconsin Board of Health and the Wisconsin Hospital Association.

The aim of the program is to collect data on injury-producing accidents, study it scientifically and attempt to determine the relationship between automotive design and injuries. The project has eight years of experience behind it and uses a highly sophisticated system of data reporting, processing and analysis. It has already produced significant information which is bound to have an influence on future automotive configuration.

Automotive Crash Injury Research (ACIR) has already been carried on in a number of states, and we are fortunate that Wisconsin is now included in the program. Since medical data furnished by the physicians attending persons injured in automobile accidents are raw material from which this research program proceeds, it is important that medical report forms for the program be completed fully and conscientiously. The forms will be delivered to the hospitals to which injured persons are taken by the State Highway Patrol, and they will be forwarded to the State Medical Coordinator of the program upon completion. Mailing instructions will appear on the medical report.

The sincere interest of every physician is merited by ACIR program. It is hoped that doctors will perceive the long-range value of the research and cooperate.—D.N.G.

THE MEDICAL FORUM

Council Elections And Appointments Announced; Rules Are Set For Scientific Program Participants

Elections, appointments and planning in scientific medicine were key features of the meeting of the Council at Land O'Lakes, Wisconsin, on July 28–29.

Dr. John M. Bell, Marinette, was named vice-chairman of the Council. He is the first to hold the recently created position. Doctor Bell is also chairman of the Council's Committee on Scientific Medicine and a member of the Council's Executive and Finance Committees.

Implementing action of the House of Delegates concerning participation of physicians and scientific programs of the State Medical Society, the following rules were proposed by the Commission on Scientific Medicine and adopted by the Council:

1. No physician who has completed his residency is to appear on the annual meeting program unless he is a member of the State Medical Society of Wisconsin. An exception will be made which requires special Council approval if the Commission on Scientific Medicine wishes a non-member physician (though eligible for membership) to speak.
2. No non-member of the State Medical Society, if he qualifies for membership, shall be a "primary author" of a scientific exhibit displayed at the annual meeting.
3. Any resident may appear on the program, whether member or not. If such person is a resident member, his name shall appear on the official program in the normal manner. If not a resident member, he must appear under the sponsorship of a member and the name of the resident and the sponsor shall appear on the program.

JOHN M. BELL, M. D.

The Council also directed a special effort to encourage membership among resident physicians.

Plans were approved to shift the annual scientific meeting of the Society to the second week in May as soon as this could be arranged.

Other actions of the Council included:

1. Appointment of Dr. Merlyn C. F. **Lindert**, Milwaukee, to membership on the Editorial Board of the *Wisconsin Medical Journal.*
2. Appointment of Dr. Harold E. **Oppert**, Viroqua, to the Commission on Public Policy. Dr. Clifford A. **Olson**, Baldwin, to the Commission on Public Relations and Communications and Dr. Richard B. **Windsor**, Sheboygan, to the Division on Safe Transportation of the Commission on State Departments.
3. Confirmation of Dr. John T. **Sprague**, Madison, as assistant treasurer of the Society and assistant treasurer of Wisconsin Physicians Service.
4. Reappointment of Dr. Albion H. **Heidner**, West Bend, as chairman of the American Medical Education Foundation (AMEF) Campaign for Wisconsin.

The Council also named Doctors Robert G. **Zach**, Monroe and Robert J. **Samp**, Madison, to represent the State Medical Society at the forthcoming AMA Congress on Medical Quackery to be held in Washington, D. C. on October 6–7. Doctor Zach is chairman of the Society's Commission on Public Policy and Doctor Samp is medical director of the Wisconsin Division, American Cancer Society.

Plans to distribute complimentary copies of *AMA News* to opinion leaders in Wisconsin were approved.

The Society has been invited to name a physician to serve on a National Advisory Committee to Review Vital Statistics Laws and the Council authorized Dr. Nels A. **Hill**, Madison, president-elect, to make the appointment.

ANNOUNCE APPOINTMENT OF MEDICAL EXAMINERS

Three new members and one reappointment to the State Board of Medical Examiners have been announced by Governor Gaylord **Nelson.**

New members are Richard J. **Rogers**, M D., Elkhorn; David A. **Werner**, M.D., Sheboygan; and Michael **Sanfelippo**, D. O., Milwaukee. William C. **Henske**, M.D., Chippewa Falls, was reappointed.

Preliminary Annual Meeting Plans Announced

Dr. Roy B. Larsen, Wausau, was named chairman of the Commission on Scientific Medicine for the coming year at a joint meeting of that Commission and the Scientific Committee of the Council held in Madison on July 16.

Selected for specific assignments for the 1962 annual meeting were: Dr. Richard W. Farnsworth, Janesville, program chairman; Dr. A. R. Curreri, Madison, luncheon chairman; and Dr. Philip T. Bland, Westby, scientific exhibits chairman. Dr. George Collentine, Jr., Milwaukee, was named commission representative to plan Circuit Teaching Programs.

R. B. LARSEN, M. D.

ANNUAL MEETING PLANS

In developing general plans for the 1962 annual meeting, to be held May 7 to 10 in Milwaukee, the Commission decided to present general, coordinated programs for the morning scientific sessions rather than special programs by the two medical schools.

For the 1962 meetings, the morning programs will be as follows:

Tuesday, May 8—"Your Female Patient and Special Problems She Presents"—under the direction of the University of Wisconsin Department of Obstetrics and Gynecology.

Wednesday, May 9—"Automotive Injuries and General Trauma"—under direction of the Wisconsin Academy of General Practice.

R. W. FARNSWORTH, M. D.

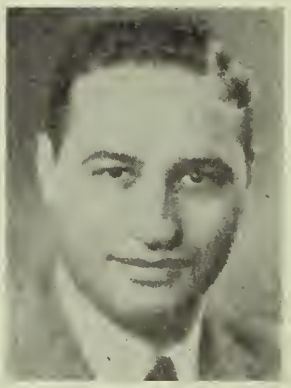
Thursday, May 10—"Wet Clinic on Dermatology and Allergy"—under the direction of the Marquette University School of Medicine, Wisconsin Dermatological Society and Wisconsin Society of Allergists.

General plans were also made for the specialty programs to be held during the three days.

SPECIAL ACTIONS

In other actions, the Commission:

1. Reviewed the Speakers Service for the past year and made revisions in some aspects for the coming year. It was suggested that all smaller county societies be contacted, volunteering more assistance in program planning on a full-year basis by the State Medical Society staff.
2. Transmitted to the Council a recommendation that the House of Delegates meeting be held in the fall, and a strictly scientific program be held in the second week of May each year.
3. Expressed appreciation to Dr. M. C. F. Lindert, Milwaukee, retiring chairman of the Commission, for his years of service and active interest in the scientific affairs of the State Medical Society.



A. R. CURRERI, M. D.

Milwaukee Conference Program Is Announced

Fourteen nationally known physicians will discuss the newest developments in medicine at the first annual Milwaukee Medical Conference, Oct. 19 and 20, at the Milwaukee County General Hospital. The final program has been announced by Dr. Wilson Weisel, Society Program Chairman and General Chairman of the Milwaukee Medical Conference. The conference is sponsored by The Medical Society of Milwaukee County.

The two-day conference will be divided into three sessions. The general theme of the program on Thursday morning, Oct. 19, will be "Clinical Pathological Physiology of Disease." "What's New in Medicine?" will be the theme of the Friday, Oct. 20, program. The entire Friday program will be devoted to presentations on the latest developments in various medical fields, including allergy, dermatology, psychiatry, pediatric surgery, and reconstructive surgery.

All physicians attending the conference will be welcome at the program planned by the Orthopaedic Club on Wednesday, Oct. 18. Doctors will also be able to attend the sessions of the joint meeting of the Wisconsin Society of Pathologists and the Wisconsin Society of Medical Technologists being held Friday, Oct. 20, through Sunday, Oct. 22.

Physicians and their wives will attend "A Night in Old Milwaukee" buffet supper at the Wisconsin Club Thursday evening, Oct. 19.

Complete details on the program will appear in the September issue.

State Medical Society Testimony Presented At House King Bill Hearings In Washington

Dr. Robin Allin Gives Statement Against Bill

The State Medical Society of Wisconsin, through Dr. Robin N. Allin, Madison, presented its opposition to the King Bill (H.R. 4222), to provide medical care for the aged through Social Security, in hearings on the measure before the House Ways and Means Committee held the latter part of July.

Doctor Allin, who is chairman of the Committee on Health Economics of American Life, gave a 16-page statement to the committee expressing Wisconsin medicine's objections to the measure. Robert B. L. Murphy, general counsel for the State Medical Society, accompanied Doctor Allin.

Citing the medical society's dedication to progress in scientific medicine and improved public health Doctor Allin pointed to such accomplishments as:

1. The nation's first basic science law.
2. The nation's first operating Workmen's Compensation Act.
3. The first to set up machinery for approving private health insurance carriers with policies providing certain high quality benefits.
4. One of the first state medical society sponsored and operated Blue Shield Plans to offer major illness coverage, plus the unique concept which pays the physician's "reasonable" charges.
5. An old age assistance program, second to none in the nation.

"In each of these achievements, the State Medical Society of Wisconsin has either led the way or joined with others to bring about the desired progress," Doctor Allin stated.

"Let me emphasize that as a state medical society, our concern is with the health and well-being of *each* of Wisconsin's 4 million citizens . . . young and old alike," he continued. "Our state has about 395,000 citizens who are 65 or over. Their health care needs are met in direct proportion to their frequency and severity . . . just as we direct proportionate attention to the health care needs of some 400,000 youngsters under age 5 who have their entire lives before them."

ROBIN ALLIN, M. D.

"Where need exists, a remedy is devised."

"As physicians who treat the population from birth until death, we see no need for developing a scheme, at once drastic and dramatic, as proposed in H.R. 4222, to claim to do for the elderly through the federal government what can be and is being better accomplished locally."

"As physicians we believe that the health care needs are being met more speedily, at lower cost, and with greater assurance of high quality of care at the local rather than the federal level."

"Yet, by some strange and illogical deduction, the supporters of H.R. 4222 would remove health care from the category of those expenses which can be planned for adequately in all but a small number of cases. They would remove it from personal responsibility and make it a federal responsibility."

Doctor Allin contended that food, shelter and clothing are as essential to good health as adequate immunization or medical care, yet no one would suggest that everyone over 65, who is eligible for Social Security benefits, should have his rent and food bill paid for through the federal government.

Stating that most patients want to and can pay the costs of medical care, he added, "At least 78 per cent of Wisconsin's citizens have some type of voluntary health insurance . . . At least 51 per cent . . . over 65 have purchased voluntary, prepaid coverage . . ."

What facilities does Wisconsin already have? Doctor Allin cited the system of county and state hospitals for welfare patients and those who can pay part or all of the costs are cared for.

Pointing to Wisconsin's comprehensive Old Age Assistance Law under which a person over 65 can receive aid even though he owns his own home, has liquid assets up

(Continued on page 464)

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Society Statement Presented On King Bill

(Continued from page 463)

to $500 and insurance with a cash value up to $1,000, he added:

"While this old age assistance program provides cash to meet the individual's personal budget, it provides in addition that the individual shall be able to receive all—and I repeat *all*—necessary surgical-medical-hospital, dental, pharmaceutical—in fact, all necessary health care . . ."

"In addition, should a person 65 years of age or older be fully capable of handling the day-to-day expense of food, shelter, clothing and the like but find it impossible to handle his health care expense, this same Wisconsin Statute provides that the old age assistance program will provide for *any and all health care he needs from the physician and hospital of his choice.*"

". . . we regard this Statute as a first-class example of what can be done without the King Bill."

Doctor Allin further pointed out that Wisconsin is moving ahead with implementation of the Kerr–Mills Act, with every effort being made to bring about its passage during 1961.

"It is *not* just another piece of relief legislation," he added.

Moving on to direct comment on the King Bill, Doctor Allin objected to four findings stated in the bill:

1. "As a physician for more than 25 years, . . . I take strong exception to the first finding which states that: 'the heavy costs of hospital care and related health care are a grave threat to the security of aged beneficiaries'."
2. "Finding 2 . . . states that: 'most of them are not able to qualify for and to afford private insurance adequately protecting them against such costs.' . . . I am informed by those in a position to know, that it is inaccurate and that increasingly comprehensive insurance is available to people 65 and over."
3. "Finding 3 states . . . that 'many of them are accordingly forced to apply for private or public aid, accentuating the financial difficulties of hospitals and private or public welfare agencies and the burdens of the general revenues.' . . . the bill should make it clear what is meant by the word 'many.' The finding certainly is nothing new . . . lack of foresight or personal misfortune have always required elements of the population of all ages to apply for private or public aid."
4. "The 4th finding that: 'it is in the interest of the general welfare for financial burdens resulting from hospital services and related services required by these individuals to be met through social insurance,' certainly has no medical basis."

Doctor Allin also argued that the stated purposes of the bill, together with the prohibition against interference with the practice of medicine or with institutions which care for the sick, are not consistent with the actual provisions of the bill.

"Since an institution for the care of the sick is not self operating, the many economic and other controls provided by this bill will inescapably have an impact upon patterns of practice not only on the part of the specialties named in the bill but also upon the other physicians on the staffs of such institutions."

". . . pathology, radiology, physiatry and anesthesiology are four specialties of medicine; these fields are specifically not exempt from the definition of 'medical or surgical services' under the wording . . . of the bill."

"Under Wisconsin law no physician can be employed by a hospital, which means that the exceptions in the King Bill may sweep these four specialties into its net, despite state law to the contrary and despite the many professional considerations which caused the adoption of such state legislation."

"As a physician, I repeat that I find it misleading for the bill to claim . . . that there shall be no 'supervision or control over the practice of medicine or the manner in which medical services are provided'."

"Note as a single example, that the teaching programs in a particular institution are not to be those approved by the medical staff, or by the trustees or the owners of the institutions. No, such teaching programs must be those approved by someone unnamed in the bill who in turn must be approved by the Secretary of Health, Education and Welfare."

Doctor Allin also furnished the committee with numerous other examples where the bill involves either the activity of physicians or their relationships to patients 65 and over, or which involve direct or indirect supervision or control over the practice of medicine— despite contrary assertions by the drafters of the bill.

(Continued on page 465)

Physicians' Fees Low In Living Cost Scale

A belief seems to be prevalent in these days of rising costs that it costs too much to be sick, and that doctors, who are responsible for the care are also responsible for the cost.

The Bureau of Labor Statistics, United States Department of Labor, is responsible for the following figures—indicating that perhaps the physician's fees haven't kept pace with other rising costs in our economy:

Item	*Per Cent Increase 1936–1960*
Hospital Rates	370.1
Men's Haircuts	276.0
Shoe Repairs	186.1
Movie Admissions	155.4
Public Transportation	146.4
Food	138.9
Laundry Services	135.3
Auto Repairs	101.8
Dentists' Fees	101.0
General Practitioners' Fees	89.9
Surgeons' Fees	74.4

Over-all increase from 1936–1960 on all items was 113.3 per cent.

Personal Service Corporation Bill Is Signed By Governor

Bill 587, A.—which will permit many self-employed persons to have the same privileges in establishing retirement programs as are now available to the employed—has passed both the Assembly and Senate and was signed into law by Governor Gaylord Nelson on August 4.

The new law will allow professional persons, licensed, certified, or registered under state law, to incorporate for the purpose of deferring taxation on retirement funds until benefit is received.

The legislation is intended to accomplish two things:

1. Give the self-employed person the same tax treatment enjoyed since 1942 under federal income tax laws by those who could qualify as "employees" under the Internal Revenue Code.
2. Insure that service corporations authorized under it do not practice a profession or render a service to the public; the professional or other individual associated with the service corporation would continue to render service with the same legal liability and continue the same contract and other relationships with the person served which have been established previously by general law.

The situation which made the legislation desirable is, in brief: the self-employed person has had to provide his savings for retirement and similar purposes out of *post-tax* dollars, whereas those who could qualify as "employees" to the satisfaction of the U. S. Treasury could enjoy such deferment and benefits out of deductible or *pre-tax* dollars.

Professional groups are under a further disability in that courts have almost universally forbidden the practice of professions through corporations established on a for-profit basis.

In November 1960 the U. S. Treasury announced that it would recognize certain kinds of organizations of the self-employed for federal income tax purposes. Bill 587, A. was drawn to meet the requirements set forth by the Treasury and authorize such organizations in Wisconsin.

Objections To The King Bill

(Continued from page 464)

In closing, he listed 5 major conclusions, that H.R. 4222:

"1. is unnecessary public health legislation,

2. fails to contain any real assurance of achieving what it claims in the broad strokes of its purpose clauses,

3. provides at most only partial health services for a segment of the population, but does this regardless of need,

4. is unfair in looking after only a portion of those age 65 and over if there is *any* soundness in the premise that health problems at those ages constitute a pressing social problem demanding immediate legislative correction, and

5. contains numerous, intended and significant controls over the professional services of practicing physicians, and those in training, despite the claims of noninterference and the often publicized assurances that this bill does not involve physicians."

Counselors Hear Need For Medical Students

Four physicians and a medical student appeared before some 250 high school guidance counselors June 29 to explain the need for more qualified medical students.

Dr. David **Smith**, assistant professor of pediatrics at the University of Wisconsin Medical School, was the main speaker. On the panel were Dr. Robert S. **Gearhart**, Madison, Dr. T. H. **McDonell**, Waukesha, Dr. Russell F. **Lewis, Jr.**, Marshfield, and Jerome **Gunderson**, medical student at the university.

The program was part of the 1961 Conference on Guidance and Counseling of the university's Department of Education.

A tape recording of the presentation is available from the State Medical Society for use in activities for the recruitment of medical students.

DOCTOR CLARK HEADS STATE HEALTH BOARD

The State Board of Health announced July 24 the re-election of Dr. William T. **Clark**, Janesville, as president, and Dr. Joseph C. **Griffiith**, Milwaukee, as vice-president for one-year terms.

The board also reported the appointment of A. F. **Wileden**, University of Wisconsin Professor of Rural Sociology, and Karl H. **York**, administrator of St. Luke's Hospital, Racine, and the reappointment of Herbert **Vonier**, Milwaukee labor official, to the advisory hospital council. York was also named to a three-year term on the advisory committee on hospital regulation and approval.

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Views Commitment Laws, Cystic Fibrosis Plan

The Commission on State Departments, meeting in Madison July 9, appointed new division members, heard remarks from various state department representatives, and discussed problems referred to it by the House of Delegates, Council and state departments.

One of the more complex problems referred to the Commission was "The Case of Terrence Donovan." Donovan, a Peshtigo youth with a history of mental illness, killed a girl last year and the crime focused attention on Wisconsin's commitment laws.

The Council reviewed the case last April and referred the general problem exemplified in the case to the Commission.

"Fundamentally, it goes back to the regulation on 'What is insanity?'" said Dr. E. D. Schwade, Milwaukee. "This is as much a legislative problem as a medical one; there is a question of constitutional rights."

The question was referred to the Division on Nervous and Mental Diseases

CYSTIC FIBROSIS PROGRAM

Dr. Patricia McIllece, Madison, Medical Director of the Bureau for Handicapped Children, appeared to explain a proposed Department of Public Instruction pilot program to assist families of children with cystic fibrosis.

"We hope to be more than just a drug dispensing agent," she said, pointing out that the Bureau hoped to offer transportation to schools and special equipment for the children.

However, Doctor McIllece stated that providing drugs was going to present difficulties, since so many are used in combatting the disease. She asked the advice of the Division in this matter.

"We see cystic fibrosis as a large problem, even though the children are few," she concluded.

Action on the pilot study was referred to the Division on Handicapped Children for study and a report which would be referred to the Council.

TUBERCULOSIS CONTROL

The Commission also discussed a resolution passed by the House of Delegates directing that the Division on Chest Diseases "enlist the aid of the appropriate legislative and executive branches of the State of Wisconsin to formulate a plan of study of state tuberculosis control which would result in definite recommendations based on a complete and adequate study of both state and county tuberculosis control."

Dr. Carl N. Neupert, State Health Officer, stated that it was unlikely that state institutions would be set up at a time when the hospitalization factor of the disease has been reduced. However, he felt that there was merit in a plan which would involve counties working together on the problem.

The resolution was referred to the Division on Chest Diseases.

NURSING HOMES

A request by the Wisconsin Association of Nursing Homes for State Medical Society representation concerning accreditation of nursing homes was heard by the Commission. It was decided that a member of the Division on Aging would be appointed.

State Departments Commission Appoints New Division Members

Appointments of members and advisors to the various divisions of the Commission on State Departments were made July 9. Those appointed are as follows:

DIVISION ON AGING

Members

Dr. S. E. Sivertson, La Crosse
Dr. Walter C. Kleinpell, Kenosha
Dr. George M. Shinners, Green Bay

Advisors

Dr. Milton Feig, State Board of Health
Mr. Paul Fleer, State Board of Health
Mr. T. J. Lucas, Sr., Department of Public Welfare

DIVISION ON CHEST DISEASES

Members

Three terms expiring in 1961 to be filled at a later date.

Advisors

Dr. Milton Feig, State Board of Health
Dr. Josef Preizler, State Board of Health

DIVISION ON HANDICAPPED CHILDREN

Members

Dr. Lloyd Williams, Appleton
Dr. Robin Allin, Madison
Dr. Donald Jeffries, Shawano

Advisors

Dr. Patricia E. McIllece, Department of Public Instruction
Mr. John Melcher, Department of Public Instruction

DIVISION ON MATERNAL AND CHILD WELFARE

Members

Dr. R. C. Brown, Neenah
Dr. B. P. Waldkirch, De Pere
Dr. F. G. Johnson, Jr., Superior
Dr. George H. Stevens, Wausau
Dr. J. D. Wilkinson, Oconomowoc
Dr. Floyd Steffan, Plymouth

Advisors

Dr. James L. Wardlaw, Jr., State Board of Health
Mr. Frank Newgent, Department of Public Welfare

DIVISION ON NERVOUS AND MENTAL DISEASES

Members

Dr. Henry Veit, Milwaukee
Dr. C. L. Kline, Wausau
Dr. J. T. Petersik, Oshkosh
Dr. G. B. Tybring, Madison

Advisors

Dr. Walter J. Urben, Department of Public Welfare
Dr. Charles Belcher, Department of Public Welfare

(Continued on page 467)

Governor Sets Plan For Traffic Safety

Dr. J. L. Weygandt, Sheboygan Falls, a member of the Division on Safe Transportation of the Commission on State Departments of the State Medical Society attended a conference on traffic safety, called by Governor Gaylord Nelson, on July 19.

At the conference, the Governor outlined a list of 24 items which he feels require legislative action before Wisconsin can attain the maximum in traffic safety.

He called on the organizations represented to study the proposals and to conduct educational programs on their importance prior to introduction in the legislature.

Division On Aging Discusses Regional Home Care Workshop

A report on the Regional Workshop on Home Care, held in Chicago May 24–26, was the main topic of discussion at a meeting of the Division on Aging of the State Medical Society's Commission on State Departments and the Joint Council on Aging in Wisconsin held July 6.

Dr. N. A. Hill, Madison, Dr. Milton Feig, State Board of Health, and Warren Von Ehren, Wisconsin Hospital Association, reported on the workshop.

Conclusions were that: selection of patients for home care service is a key to a successful program, that different approaches are required for rural and urban programs, and that personnel, teamwork and adequate finances are vital factors to a successful program.

It was agreed that each organization consider formal endorsement of home care programming as a valuable adjunct to adequate health care.

Also discussed was a proposed Home Care Conference to be held in 1962 under the sponsorship of the State Medical Society.

Member organizations of the Joint Council on Aging in Wisconsin were also urged to submit names of those desired to receive information and invitation to a National Conference of the Joint Council to Improve the Health Care of the Aged, to be held in Chicago December 15–16 of this year.

Dr. Elmer C. Kocovsky, Wauwatosa, reviewed the accreditation program of the American Nursing Home Association and Mrs. Pearl Dawson, Janesville, urged support for a series of regional meetings for nursing home operators being held on a trial basis in the Janesville area.

Division Members Are Listed

(Continued from page 466)

Dr. Leonard J. Ganser, Department of Public Welfare

Dr. James L. Wardlaw, Jr., State Board of Health

Mr. A. B. Abramovitz, State Board of Health

Dr. Jack Edson, Department of Public Welfare

Dr. Seymour Halleck, Department of Public Welfare

Dr. John Toussaint, Department of Public Welfare

DIVISION ON PUBLIC ASSISTANCE

Members

Dr. C. A. Olson, Baldwin

Dr. W. W. Meyer, Medford

Advisors

Dr. John R. Allen, Department of Public Welfare

Mr. T. J. Lucas, Sr., Department of Public Welfare

DIVISION ON REHABILITATION

Members

Dr. Louis Kagen, Milwaukee

Dr. R. E. Housner, Richland Center

Advisors

Mr. E. L. Hoskins, Department of Public Welfare

Mr. A. E. Town, Board of Vocational and Adult Education

DIVISION ON VISUAL AND HEARING DEFECTS

Members

Dr. Richard J. Fogle, Racine

Dr. James V. Bolger, Waukesha

Dr. John B. Hitz, Milwaukee

Advisors

Mr. T. J. Lucas, Sr., Department of Public Welfare

Mr. John Melcher, Department of Public Instruction

Dr. Patricia McIllece, Department of Public Instruction

DIVISION ON SAFE TRANSPORTATION

Members

Two terms expiring in 1961 will be filled following appointment of a new chairman by the Council.

Advisors

Mr. John Thompson, Motor Vehicle Department

DIVISION ON SCHOOL HEALTH

Members

Dr. E. E. Bertolaet, West Allis

Dr. James C. H. Russell, Fort Atkinson

Advisors

Dr. James L. Wardlaw, Jr., State Board of Health

Mr. Orlo Miller, Department of Public Instruction

Mrs. Dorothy Barnett, Board of Vocational and Adult Education

Mr. Oscar R. Cade, State Board of Health

MEDICARE CASES ARE DOWN DURING JUNE

Medicare cases in Wisconsin during June numbered 576, according to a report just received. This was a decrease from the 805 cases treated in May.

Payments for the month to Wisconsin physicians amounted to $41,742.

For the year to date, 2,698 Medicare cases have been treated by state physicians with total payment of $196,322.

Correction

In the July issue of the *Wisconsin Medical Journal*, page 425, House of Delegates' Reports, an error was made in the report of the Commission on State Departments. In the section on "Standards for Tuberculosis Testing," No. 2 should have read: "The recommended test done should be .0001 mgm.," instead of ".001 mgm."

Cancer Coordinating Committee Discusses Educational Program

Members of a Cancer Coordinating Committee, made up of representatives of organizations interested in cancer, outlined a long-range program of both lay and medical activity at a meeting July 15 at the State Medical Society headquarters in Madison.

Some of the suggestions and activities are:

1. **A recommendation that the State Medical Society immediately study and implement statewide health educational efforts through television, including promotion of cancer detection and control.**
   It was suggested that this be done through the employment of personnel to assist county medical societies and local television stations in arranging appropriate programs, with possible financial aid for a pilot project through the National Institutes of Health.
2. A recommendation that colon and rectal cancer be included in the curricula for the Teaching Circuits of the State Medical Society.
3. **A proposed annual conference on cancer and heart was discussed.**
4. A recommendation that the medical editor of the *Wisconsin Medical Journal* invite appropriate physicians to submit short, practical articles on cancer detection and treatment.
5. **Medical-Dental Cancer Clinics were discussed.**
6. It was suggested that specialty societies be urged to use cancer speakers at their regular meetings.
7. **All members of the Committee on Cancer of the State Medical Society were urged to contact program chairmen of their county societies to urge inclusion of cancer topics in their meeting programs.**

Dr. J. M. **Lubitz**, Brookfield, representing the Wisconsin Society of Pathologists, reported that his society has undertaken an extensive statewide study of the availability of cytology facilities and services. The coordinating committee agreed that cytology programs should be encouraged both among the professions and non-medical people.

Racine Medical Society Provides Resuscitators

As lifeguards man the beaches in Racine this summer, among the equipment issued to them are mouth-to-mouth resuscitators donated by the Racine County Medical Society.

Philips Roxane, Inc. New Drug Company

A new drug manufacturing enterprise known as Philips Roxane, Inc. introduces itself to Wisconsin physicians in an advertisement appearing in this issue of the *Wisconsin Medical Journal.*

An international organization with operations in the electronic, pharmaceutical and chemical fields, Philips Roxane has acquired several American affiliates to enhance its research and marketing operations in this country, and has erected a new headquarters plant in St. Joseph, Missouri.

Quotable Quotes On Federal Legislation

Baptists Take Stand

"The American Baptist Convention turned down a proposal endorsing a medical care program for the aged operated by the Federal Government. . . Instead, it adopted a resolution urging American Baptists to consider their personal responsibilities and proposing that they refrain from asking the federal government for additional aid."—*Legislative Roundup,* June 30, 1961.

Kerr–Mills Moves Ahead

At the closing session of the recent conference on elder care held by HEW, Dr. Edward **Annis**, Miami, Fla., got up to inquire if the Kerr–Mills Act has not made exceptional progress.

"Dr. Thomas **McKneely** of Social Security Administration, responded that it was moving ahead faster than medical vendor payment plan did in comparable period following its enactment in 1950. The SSA official went on to ascribe this swift embracement in part to AMA's aggressive endorsement. . ."—*Washington Report,* June 19, 1961.

Threat To Democracy

"Former President **Eisenhower**, speaking before the First World Conference of Local Governments on June 15, declared that excessive centralization of government is a never ceasing threat to democracy. . . He warned: 'The mania that some overzealous central agencies seem to have developed for wanting to dominate rather than serve local government threatens to sap the vitality and creative initiative of community institutions. . . One of the deceptive doctrines is that political centralization is the great detergent which can cleanse all the nagging social, economic, educational, and organizational disorders that beset mankind'."—*Legislative Roundup,* June 16, 1961.

Revise Estimates

"Social Security planners of H.R. 4222 only recently decided that their original estimate of the costs of its nursing home care benefits was too low. . . The original estimate was $9 million the first year of operation. . . Now, social security actuaries are thinking in terms of between $25 million and $225 million."—figures from *The Wall Street Journal,* as quoted in *Legislative Roundup,* June 16, 1961.

"News" Sees Threat

"The *New York Daily News* took HEW Secretary **Ribicoff** to task for his speech before the graduating class of the University of California Medical School. In an editorial, the publication pointed out that 'one could detect a veiled threat that, if the doctors don't play along with the politicians in furnishing more and more 'free' medical care, the politicians will take over the doctors'."—*Legislative Roundup,* June 16, 1961.

the Wisconsin Medical Journal

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Surgical Principles Involved in the Treatment of Extensive Burns

By SIDNEY K. WYNN, M.D.

Milwaukee, Wisconsin

THIS REVIEW of surgical principles involved in the treatment of extensive burns is based on recent experiences in treating extensive burns from the combined medical and surgical standpoint. Three patients with severe burns recently treated undoubtedly would have succumbed from infection and other complications without a joint medical and surgical effort. The most severely burned patient was a 19-year-old man who had 85% of his body burned, 65% of which was third degree. As far as we know, this patient had the most extensive burn on record completely skin grafted, without needing amputations of extremities, who went on to complete healing. The extent of these burns is illustrated in Figures 1, 2, 3 and 4. We would like to emphasize and give due credit to the tremendous amount of cooperation given in the treatment of these burns by the resident and nursing staffs at the Milwaukee County and Mount Sinai Hospitals.

The patient with a severe burn should be placed immediately on sterile sheets on a Stryker or Foster bed. Isolation techniques are used with cap, gown, mask and gloves to prevent infection from the very beginning. It is important to establish life lines early. The urinary Foley catheter is used and urinary output measured accurately. The early intensive administration of intravenous solutions necessitates the use of a polyethylene catheter in a vein from the outset. It is important that veins be preserved in order to make sure that as treatment progresses a means of giving intravenous fluids is available. It is best to start with peripheral vessels and work toward the body so that high thromboses do not block peripheral vessels too soon. One who is expert in finding veins should start the fluids. We do not use a tracheotomy to establish a proper airway unless absolutely necessary in patients who have had a large facial burn without inhalation damage. If this is going to be necessary, however, it should be done early as an elective procedure.

Presented at the 120th annual meeting of the State Medical Society, Milwaukee, May 3, 1961.

Doctor Wynn is assistant clinical professor of plastic surgery, Marquette University School of Medicine; assistant clinical professor of oral rehabilitation, Marquette University Dental School; attending plastic surgeon, Milwaukee Children's Hospital; chief of plastic surgery, Milwaukee County Hospital; chief of Department of Surgery and Section of Plastic Surgery, Mount Sinai Hospital, Milwaukee.

Medical illustrations by Mr. R. Albertin, Marquette University School of Medicine, Milwaukee.

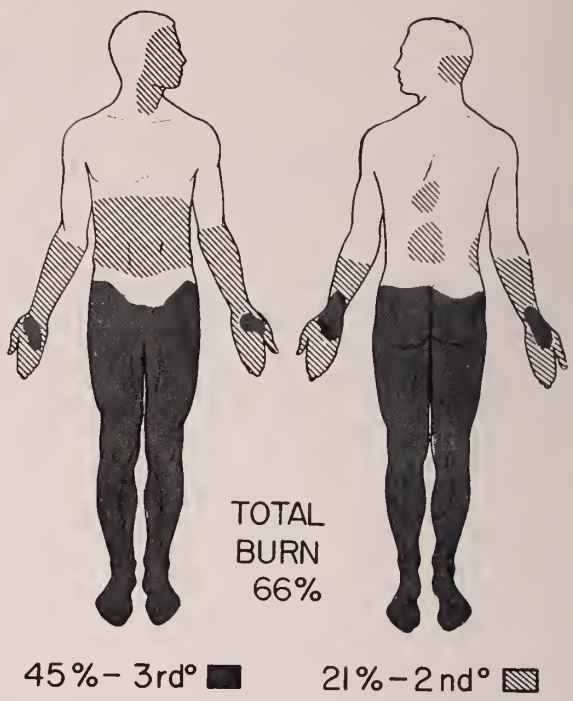

Fig. 1 (left)—Postoperative skin grafted appearance of legs of a 26-year-old man following an alcohol explosion burn which covered 66 per cent of his body. This picture was taken six months after the accident.

Fig. 2 (above)—Diagram indicating the extent and location of the burns of the patient shown in Figure 1.

The entire burn era and normal surrounding skin should be washed with pHisoHex and rinsed with saline solution. Large blisters are ruptured and debrided and then a decision must be made whether to use open or closed therapy. Most burns do best under open therapy and have less chance of infection. However, circular burns of the extremities and burns of the hands should be dressed early in a position of function. If good nursing care is not immediately available, burns are best dressed closed to help prevent external contamination. Later when conditions have improved, the dressings can be removed and conversion to open air therapy accomplished.

For the initial dressings we use a single thickness of Owens neomycin-impregnated rayon gauze moistened in saline solution next to the burn area covered by a padded dressing. The usual circular pressure dressings are placed over these. If the patient is started on closed therapy in this fashion, and there is no evidence of infection or temperature elevation, it is often possible to leave these dressings alone for 5 to 10 days. The burns of lesser extent at the time of initial dressing will be found to be completely healed and the other areas will often have developed a dry clean eschar beneath the dressing from which the rayon gauze can be easily peeled. Conversion to the open air therapy at this point is usually possible.

The Principles of Debridement

Individualized timing is important. There are several factors involved.

1. *Ability to recognize the depth of the burn:*

It is impossible early to assess the depth of burns with accuracy. Any burn which has not healed by the 21st to 30th day for all practical purposes must be considered third degree. The history of the burn may often help. If one has been burned by molten metal, di-

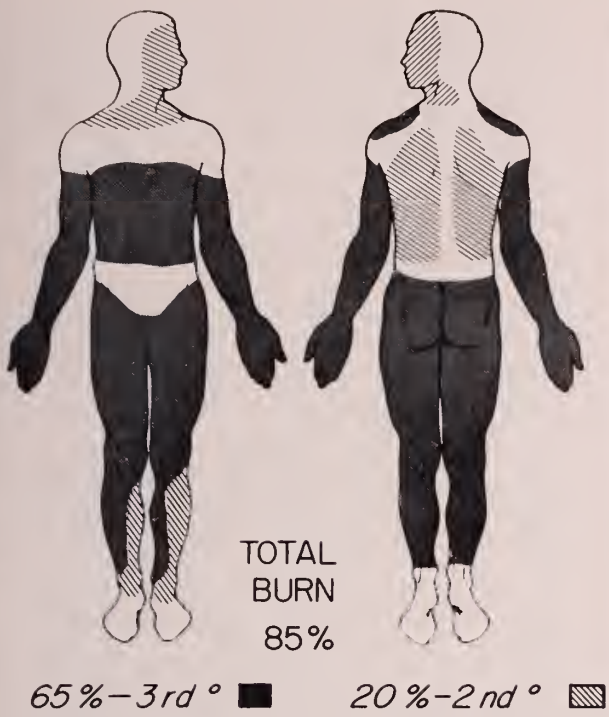

Fig. 3 (above)—Diagram showing extent and location of burns suffered by a 19-year-old man in an alcohol explosion.

Fig. 4 (right)—Postoperative skin grafted appearance of patient six months after treatment. Right hand will require secondary reconstructive surgery due to depth of burn and tendon involvement.

rect contact with live steam at the source, or open fire, it is a good possibility these are of the deepest variety; however, this can not always be accurate.

2. General condition of the patient:

In an old, debilitated patient, extensive debridement too soon may be fatal. In this situation one should go slowly and allow nature to take its course. Often a spontaneous separation of the eschar will occur and this will save the patient an operative procedure.

3. Extent of the burn:

In a small burn, early debridement with complete excision of all areas which are known third degree can hasten the end result.

4. Location of the burn:

Earlier care to areas over flexion creases of the extremities, hands, and face is indicated. In these areas fast coverage helps preserve function and cosmetic appearance.

5. Etiology of the burn:

Burns caused by both heat and chemicals, such as in the case of exploding cleaning fluids, offer debridement problems not found in the usual heat burn.

6. Type of eschar:

When the patient has a thick parchment-like eschar and has no pain response to pinprick, early surgical removal if possible will

hasten cleaning of the area and prevent anaerobic infection. If the eschar is thin and pliable, though almost parchment in appearance, this may indicate only a deep second degree burn; and it is well to delay debridement in the hope that these areas will peel between the third and fourth week and underlying epithelialization take place.

7. Amount of infection present:

Purulent material beneath the eschar may indicate a deep necrotic burn. It is wise to remove such an eschar in order to establish a suitable granulation bed earlier and prevent systemic infection.

Preparation of Therapy

The production of optimal granulation tissue is of great importance and depends on three main factors.

1. Prevention of infection with both general and local antibiotics:

Doctor Waisbren's article in this issue discusses the medical therapy of burns and the general antibiotic regimen. Our local therapy principle is to prevent bacterial toxins and pus from forming. For this reason we have developed a wide-spectrum antimicrobial solution.

2. Type of dressing used during preparation of the extensive granulating wound:

The single-thickness Owens rayon gauze, either plain or neomycin-impregnated, is preferred. Occasionally the neomycin rayon gauze is used along with the wetting by the local antibiotic solution that has been developed. For facility and care this rayon gauze is changed every 24 to 48 hours; and in the very extensive burn, it is probably best to do this in the operating room. The patient can easily be wheeled on the Stryker frame or Foster bed without transferring him to the operating table.

This type of dressing accomplishes the following:

(a) Keeps granulations flat.
(b) Prevents excessive adherence of the dressing to the wound.
(c) Cuts down dressing pain.
(d) Reduces the amount of destruction to any newly epithelializing areas.
(e) Still allows secretions to get through to the coarse mesh gauze placed above in order to carry off the drainage. This coarse gauze is moistened with the indicated antibiotic solution as needed and gets away from the previously used frequent dressing changes and attendant pain.

3. Change in position:

This can be accomplished by (a) frequent turning of the patient and (b) slinging extremities on frames attached to the Foster or Stryker bed. This will prevent pressure on the newly forming granulation tissue.

Skin Grafting

The next stage after debridement and preparation of the optimal granulation tissue is that of skin grafting.

1. Before skin grafting is done, it is important to have the optimum granulation bed:

This is a bed which is flat, bright pink or red, has minimal secretion and infection, and no surface necrotic material.

2. The systemic condition of the patient must be optimal:

An important index is his total serum protein concentration. It should be above 6 gm. per 100 ml.

Homografts are reserved for the most severe and extensive burns. They are used only as life-saving measures until the patient is able to withstand taking additional skin from his own body for the permanent graft. Two factors influencing longevity of a take are the age of the donor and the use of corticosteroids. The skin of the newborn infant and the skin of the very old probably evoke the least anti-body response. It is important that this skin be used with three weeks of taking it from the donor, the earlier the better. It is taken from the donor's body within six hours of death under sterile conditions. The skin is folded on itself, raw surface to raw surface, rolled in saline sponges and preserved in an ordinary refrigerator. It is possible to strip an entire body of donor skin in five or six hours with three assistants and requires approximately 20 new Brown Dermatome blades in the process.

Corticoids are helpful in patients who need homografts for an extended period. The homografts should be replaced as soon as possible. When they become red, edematous,

and blistered, it is best to remove them surgically and go ahead immediately with the autograft procedure. It was found that many of these homografts will peel off; and following scrubbing of the underlying surface, stamp autografts will take well on the scarified base. Ordinarily homograft tissue begins to slough three to six weeks following its placement. This will give adequate time usually for the patient's general condition to improve.

It was necessary to homograft the patient with 85% burns twice in order to get him in condition for autografting. This resulted in clean closed wounds while the first stamp autografts were taking and gave time for adequate healing of the limited donor sites (which were reused three times) and time for the second degree burns of the back to heal well enough to use as additional autograft donor sites.

The type of autograft to use depends upon the amount of skin available. The large sheet of skin has the advantage of better preventing contracture and producing the better cosmetic result. However, in the very extensive burn as in the cases illustrated the postage stamp technique has the advantages of more efficient use of the skin available and of being a much faster operative procedure. A large area can be covered without the use of sutures when a graft is paper-backed. The details of this technique are as follows: Use ordinary brown wrapping paper which has been autoclaved. Cut this paper into sheets 12 inches by 3 inches for facility in handling. Cover each sheet with a thin layer of Vaseline. Lay out the thin sheets of skin measuring approximately .014 to .015 of an inch in thickness on this vaselinized paper. Spread the grafts out with some tension, raw surface up. The Vaseline on the paper keeps the grafts in position and allows the tissue spaces to remain open. Cut these paper-covered grafts into squares ¾ to 1 inch in diameter and place them into a shallow pan of plasma solution. Bovine thrombin is then used to completely cover the granulating surface. It has been found that with spaces of ¼ to ½ inch between stamps complete epithelialization will take place.

Placing plasma on the grafts and bovine thrombin on the recipient granulations helps to glue each individual graft in place. The area is dressed with a fine mesh gauze covering and a minimal covering above this. If it is in an area in which no motion or possible brushing of the paper grafts is going to occur, it is possible to leave the paper-grafted areas out in the open, leaving the paper in position, and then peeling off the paper in approximately one week. This keeps down infection. Usually 100% take of these grafts ensues. One should let air at these areas as soon as possible to cut down infection between the grafts and to keep pressure away from them. In extensive circular burns of the extremities, a single-thickness covering of fine mesh gauze over the paper-backed grafts covered by a single-thickness layer of Kling soaked in the antibiotic solution which is then allowed to dry out is all that is usually necessary. This is left in place for one week and at the time of the initial dressing, the paper back of each graft is peeled off and a simple single-thickness dressing of fine mesh gauze is placed over this until epithelialization has become established. It is rare that there is not a 100% take of the paper-backed stamp grafts.

Rehabilitation

The next phase of care is rehabilitation of the patient. One of the best ways to get the open area between each graft to epithelialize still faster and maintain cleanliness is daily tubbing of the patient about three weeks following the graft procedure. The local antibiotic solution is often used as dabbing every hour or two on remaining raw surfaces. Following epithelialization, coco-butter massage of all the grafted areas is indicated to keep down debris formation and also to help soften the grafted areas.

Physiotherapy and Occupational Therapy

The phase of physiotherapy and occupational therapy follows. This is initially started with self therapy by encouraging the patient to continue coco-butter massaging to maintain motion and to build up strength. In lower extremity burns it is important that the patient is not allowed up for too long a time too soon as these areas become blue after a few minutes. The superficial circulation may have been burned out. Therefore, if the patient is going to be up for more than 10 minutes, an Ace bandage should be used for support of circulation. Later, professionally guided physiotherapy and occupational therapy will hasten motion in the joints and return of the patient to normal life.

An annoying complication is itching of the grafted areas and donor sites. This can be kept down by greasing the area and the use of antipruritics such as trimeprazine (Temaril). Another suggestion for local care is the use of a silicone spray preparation such as Topasil at the time of wet dressings and following tubbing. This protects the unburned areas of severely burned patients.

Summary

Many severely burned patients unsuccessfully treated in the past would have been saved with today's methods. Close daily liaison of the surgeon and medical man, caring for each individual complication as it arises, and directing all care from the beginning to prevention of overwhelming infection and toxemia are important factors. Burns take a tremendous amount of time and energy. Many cooperating hands are necessary to reduce debilitating pain, repeated anesthetics are needed to accomplish large dressings, debridements, and graft procedures in a minimal amount of time. The greatest amount of skin coverage accomplished in the shortest period of time helps to prevent unnecessary loss of life and preserves the greatest amount of function.

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536 West Wisconsin Avenue (3).

TENTATIVE SCHEDULE—ORTHOPEDIC FIELD CLINICS

July 1, 1961 through December 31, 1961

STATE DEPARTMENT OF PUBLIC INSTRUCTION, BUREAU FOR HANDICAPPED CHILDREN
CRIPPLED CHILDREN DIVISION, MADISON 3, WISCONSIN

LOCATION	*DATE*	*LOCATION*	*DATE*
Ashland	July 26 and 27	Racine	October 4 and 5
Wausau	August 22	La Crosse	October 10 and 11
Manitowoc	August 30 and 31	Chippewa Falls	October 18 and 19
Marinette	September 6	Eau Claire	October 26 and 27
Kenosha	September 20 and 21	Rhinelander	November 1 and 2
Superior	September 29	Sheboygan	November 8 and 9

Note: This is only a tentative list and subject to changes.

FOR: The clinics conducted by the Crippled Children Division of the Bureau of Handicapped Children are for persons under 21 years of age, who are referred by their family physician for orthopedic diagnosis and consultation. Reports of the examination are then sent to the referring physician following the clinic.

REFERRAL FORMS: Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for the individual clinics so when requesting same be sure to state approximately how many forms are needed and for which clinic or clinics. It is important that we know well in advance the number of persons desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral form will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 122 West Mifflin Street, Madison 3, Wisconsin.

The Medical Approach to Patients with Severe Burns

By BURTON A. WAISBREN, M.D.

Milwaukee, Wisconsin

THE MORTALITY of burns that involve greater than 50% of the body surface remains high in spite of numerous advances in therapy.[1] This presentation is of a group of aphorisms that have proved helpful to us in the medical management of patients in this category. The surgical principles involved have been presented by Doctor Wynn in the preceding paper, so emphasis here will be on the medical aspects of care.[2] One patient, a 19-year-old man who recovered from a total body burn of 85%, will be used as an example, since during his long course it was necessary to use all the principles of therapy, which will be presented here. Emphasis will be on practices developed within our own service but ideas and methods presented elsewhere also will be discussed.[3]

1. Care of a severe burn is a team affair:

The physical and mental labor required to take care of a severely burned patient necessitates the enthusiastic participation of a large group of people.* The exact make-up of the group can depend on the individuals available, but the minimal care requirement is for the equivalent of 24-hour special nursing care for an extended period of time. Aids to nursing such as a Stryker frame or Foster bed, a plentiful supply of sterile linen, and isolation facilities all are equally important. The physician members of the team must be well versed in aspects of fluid and electrolyte balance; chemotherapy; pulmonary, cardiac, and gastrointestinal complications; as well as in surgical matters. A daily meeting of the team is essential and at that time all orders for the day should be discussed and then written by a single individual. During the acute phase all orders should be rewritten each day. Table 1 shows an ordinary day's orders for the patient. The attitude of the team must be "can do" and feelings of discouragement at estimates of burn percentages that are presumed to be "incompatible with recovery" should be tempered by the knowledge that burn percentages are often over-estimated at the onset and that recoveries have been reported in patients with 90% severe body burns.[1] The optimistic, enthusiastic attitude of the team seems to permeate to the patient and his family and can be a big help in securing their co-operation.

2. Bacterial invasion must be aggressively fought and the patient should remain afebrile:

TABLE 1—*The Exact Orders as Transferred from the Chart of the Exemplary Patient on His 30th Hospital Day*

Orders	Explanation
Ambulatory ulcer diet Probanthine 15 mg. P.O., T.I.D., AC. & H.S. Gelusil 2 dr between meals and H.S. High protein feeding between meals and H.S.	We treat as if patient had an ulcer during entire acute phase
2 bottles of beer daily Milk of magnesia daily	Constant attention to regular bowel movements
ACTH Gel. 20 mg. I.M. every 3rd day	
I.V. in order: 1 liter 5% D/W c 2 gm. of erythromycin and 100 mg. of hydrocortisone 1 liter 5% D/W c 2 gm. of chloramphenicol 1 liter 5% D/W c 15 million units of aqueous penicillin, 100 mEq. of K^+(osKCl) and .55 mg. of hydrocortisone 500 cc. of saline c 10 cc. of gamma globulin 1 amp. of Borocca C. 1 unit of plasma 500 cc. of whole blood	Corticoids were being used to prolong homografts and large doses of K^+ were necessary because of K^+ loss due to corticoids
Butisol gr ss P.O., T.I.D. & P.R.N.	All the sedation necessary

Dressing care: Continue soaking dressings and open surface c "Dab" solution every 3 hours
Intake Output
4-hour oral temperatures recorded
Caloric intake recorded

Presented at the 120th annual meeting of the State Medical Society, Milwaukee, May 3, 1961.

From the Infectious Disease Control Unit of the Department of Medicine, Marquette University School of Medicine and the Milwaukee County General Hospital, Milwaukee.

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* All of the work presented in this paper would not have been possible without the help of the resident and nursing staffs of the Milwaukee County and Mt. Sinai Hospitals and this help is gratefully acknowledged.

TABLE 2—*Bacteria that Usually Cause Infection in Burns and Antibiotics to Which They are Sensitive*

Bacteria	Safe Antibiotics
Staphylococci	2,6-dimethoxyethyl Erythromycin
Group A. Streptococci	Penicillin G
Anaerobes	Penicillin G
Coliforms	Chloramphenicol Tetracyclines
Pseudomonas aeruginosa	Polymyxin B Oxytetracycline
Proteus	Chloramphenicol Penicillin G
Enterococci	Erythromycin Chlormaphenicol

The words "prophylactic antibiotics" are not applicable to burns since necrotic tissue plus ever-present surface bacteria result in immediate infection. In contradistinction to others, our thesis is that infections can be controlled almost completely by vigorous and specific chemotherapy used in *maximum tolerated dosages.*[3, 4] It is fortunate that relatively few species of bacteria cause the vast majority of infections in burned patients and that the antibiotic sensitivities of these species are well known[5] (Table 2). Table 2 lists these bacteria and the antibiotics to which they are sensitive.[5] Table 3 indicates several dosage regimens based on this information that have been particularly effective in preventing and controlling infection. The dosage principle followed in each has been to use the maximum amount of the drug that could be safely tolerated. The advantage of this principle is that when there is no response, a change in antibiotics can be made without first having to increase the dose of the antibiotic being used. The patient under discussion received a total of 194 gm. of chloramphenicol without evidence of toxicity. The high dosages of chloramphenicol require special mention due to recent articles warning against the use of this drug because of its rare effect on the bone marrow.[6] It is our opinion that more lives have been lost due to the withholding of chloramphenicol because of undue fear of toxicity than have been lost due to aplastic anemia due to its administration. Anaphylaxis with penicillin and staphylococcal diarrhea with the tetracyclines seem to us to at least approximate the incidence of severe toxicity with chloramphenicol, but for some reason they have not occasioned the same numbers of dire warning regarding their dangers. Chloramphenicol has by far the best toleration of the "wide-spectrum antibiotics" and up to 10 gm. per day have been administered by us to large groups of patients without untoward results. The lack of vein reaction to this drug is particularly helpful in the management of burns. In contradistinction to this is the sclerosing effect of the tetracyclines on the veins that make it almost impossible to infuse them for greater than a 10-day period.

TABLE 3—*Suggested Antibiotic Regimens for Initial and Maintenance Use in Patients With Severe Burns*

Drug Given Intravenously	Amount	Bacteria Sensitive to the Drug
Plan 1		
Chloramphenicol	6–8 gm.	Coliforms Proteus Enterococci
Erythromycin	2 gm.	Enterococci Staphylococci 60%
Penicillin G	15 million units	Anaerobes Proteus Beta hemolytic streptococcus
Plan 2		
Chloramphenicol	6–8 gm.	Enterococci Coliforms Proteus
2,6-dimethoxyphenyl penicillin (Staphcillin)	5 gm.	Staphylococci 100%
Penicillin G	15 million units	Anaerobes Proteus Beta hemolytic streptococcus

The length of "high dose" antibiotic therapy depends on the clinical course, but if possible it should be continued until major skin grafting has been completed.

In addition to the parenteral administration of antibiotics, the use of local therapy with what we have called the "dab" technique has proved most helpful. In this technique all purulent areas are dabbed at frequent intervals and all pus and necrotic tissue that will come off is gently removed. This results in a gradual "medical debridement" of large areas which can be kept clear of infection until grafting can be done. Authors who have become discouraged with local therapy may have had poor results because of the "narrow-spectrum" nature of their local solutions.[4] The constitution and make-up of the "dab solutions" can be seen on Table 4. The "dab solution" can also be injected into the cracks that appear in the eschars in order to prevent infection and pus formation. When the exposed areas are particularly large the "dab solutions" are made more dilute in order to prevent excess absorption from the vascular bed and possible

TABLE 4—*Constitution of "DAB" Solution for Use in Local Treatment of Severe Burns*

Drugs	Bacteria Sensitive to the Drug
1. One liter of Saline Solution	
2. 1 gm. of Neomycin	True Wide-Spectrum except Pseudomonas and Streptococci
3. 100 mg. of Polymyxin B	Pseudomonas Staphylococci
4. 1,000,000 units of Penicillin G	Streptococci Anaerobes
5. ± 1 gm. of Chloramphenicol	Help with Enterococci and Gram-negative Bacilli

nephrotoxicity from the neomycin or polymyxin B. In addition, the solution is dripped through the necessary dressings either by catheter or by wetting the whole bandage two or three times per day (Table 1).

Patients should be able to be kept essentially afebrile and free of pus during the major part of their hospitalization with the use of antibiotics as outlined above; and when fever does occur, its specific cause must be found. Figure 1 illustrates the effect of this vigorous program on the fever curve of the patient being used as an example.

3. Eclecticism must be the order of the day:*

The wide variety of complications and burn sites makes blind obedience to any one school of thought impossible. For instance, while we much prefer to treat without dressings, severe burns of the hands seem to do better when bandaged.

The high mortality in burns justifies the use of imaginative and original concepts as the need for them may arise even though final proof of their efficiency may not be yet available. Two therapeutic substances that fit into this category are the use of antitoxic serum from convalescent patients and the use of gamma globulin given intravenously for potentiation of the antibiotics.[7] Both of these modalities were used for the patient under discussion. He was given 125 ml. of convalescent burn plasma on the tenth hospital day when he appeared particularly ill. He improved demonstrably in the next 12 hours. This may not have been due to the antitoxic serum since other things were being done

* A philosophy that draws on many schools of thought.

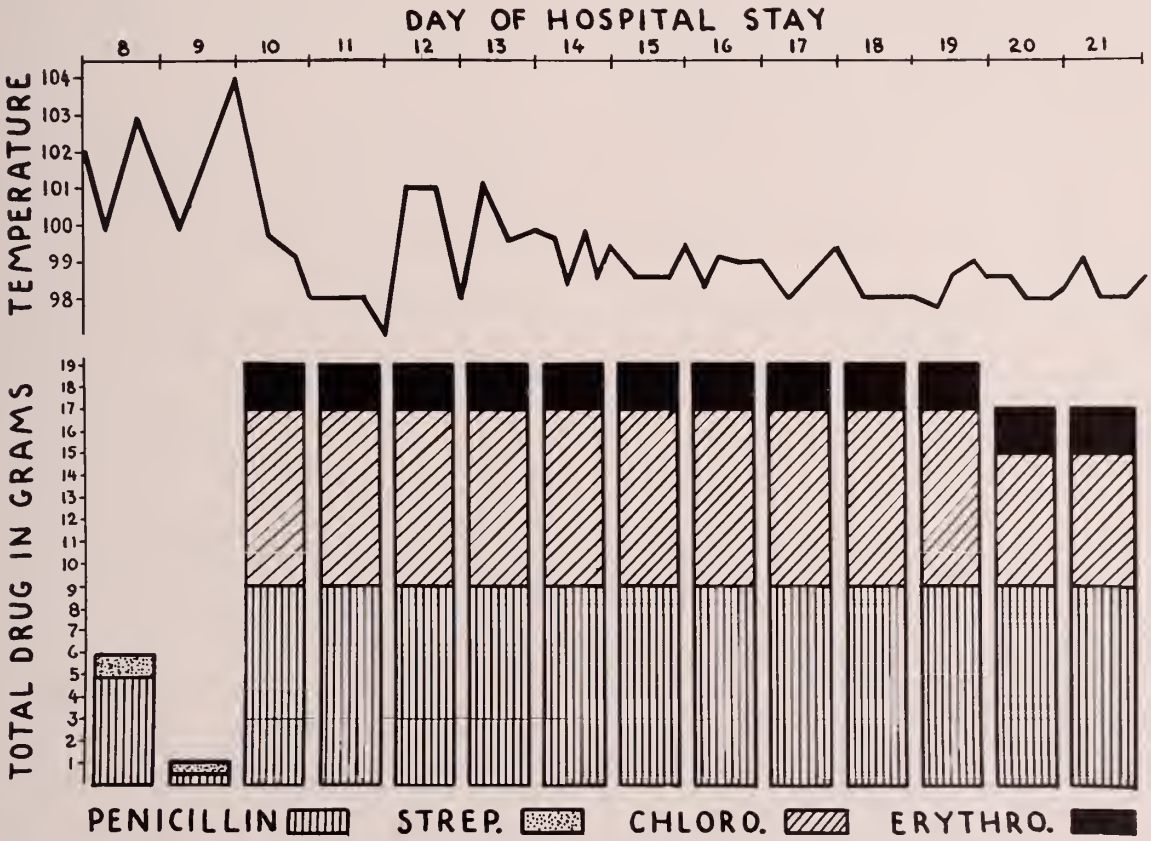

Fig. 1—Temperature chart and antibiotics received during the 8th through the 21st hospital day. This shows the response when massive therapy was instituted. (strep = streptomycin, chloro = chloramphenical, erythro = erythromycin)

simultaneously, but the excellent animal studies of Rosenthal makes it a rational approach for use when the clinical course is not satisfactory.[7] Similarly, the patient was given by infusion 10 ml. of gamma globulin dissolved in 500 ml. of saline solution daily for a period of 78 days with no sign of toxicity. We feel the efficacy of gamma globulin in potentiating antibiotics has been established by other studies and have found the intravenous route of administration* safe in over 100 patients.[8–11]

4. Guard that vein:

A prolonged period of intravenous therapy is necessary in most severely burned patients and skillful and thoughtful care of infusions is necessary to make this practicable. The surgical member of the team should take personal responsibility for the starting and care of infusions and all team members should be alert to the necessity of keeping the intravenous route open. Whenever possible the infusions should be given in veins above the waist. As soon as evidence of thrombophlebitis, either chemical or bacterial, is found the site should be abandoned. This usually occurs after five days no matter what precautions have been taken. Catheters placed in the vena cava or common iliacs are a common source of septicemia and should be used only when absolutely necessary.

The patient being discussed was on constant infusions for nine weeks. He then was maintained on oral feeding and medication for two weeks during which time he developed acute staphylococcal endocarditis. Infusions were again started and maintained for six weeks. Twenty-three "cut downs" were necessary to achieve this period of intravenous therapy which was particularly hard to maintain because of extensive burns of both arms and legs.

5. When progress is not satisfactory, search for the cause and change therapy to rectify it:

This time honored principle of therapy is particularly applicable in the case of burns. The patients should be rational, afebrile, and relatively comfortable during the entire illness. When they are not, the reason must be found. Septicemia, toxic hepatitis, renal tubular or cortical damage, lung abscess, pneumonitis, and peptic ulcer are common complications and should be systematically ruled out. Septicemias that develop while the patients are receiving high dosages of chloramphenicol and 2,6-dimethoxyphenyl penicillin most likely are due to *Pseudomonas aeruginosa* and empirical therapy with oxytetracycline (1.5 gm. intravenously daily) and polymyxin B (75 mg. intravenously daily) should be started when this complication arises.[4]

TABLE 5—*Antibiotics Used Unsuccessfully to Control the Staphylococcal Endocarditis before the Combination of Phenethicillin and Penicillin G Achieved a Cure*

Drug	M.I.C.*	Total Dosage	Response
Bacitracin	25	8,200,000 units	No
Oleandomycin	3	84 gm.	No
Vancomycin	.75	7.5 gm.	No
Ristocetin	1.5	4.5 gm.	No
Neomycin	6	8 gm.	No
Novobiocin	6	120 gm.	No
Altafur	12	7.5 gm.	No
Penicillin G	50	253.2 gm.	No
Chloromycetin	25	18 gm.	No
Streptomycin	12	38 gm.	No
Erythromycin	12	31.5 gm.	No
Phenethicillin	1.5	38 gm.	Yes
Penicillin G	50	22.8 gm.	

* M.I.C. = Minimal Inhibitory Concentration units.

The patient we are citing developed an acute endocarditis due to Staphylococcus aureus and, as shown in Table 5, 12 antibiotics were tried before this infection was cured by a combination of intravenous phenethicillin and penicillin G. Each one of these 12 antibiotics seemed to be indicated on the basis of *in vitro* studies, but it was necessary to change frequently until a therapeutic program was found that resulted in negative blood cultures and an afebrile state.

6. Normal nutritional and chemical status must be maintained:

Frequent laboratory determinations are necessary to achieve this end, and adequate amounts of blood for the performance of these tests often must be obtained by femoral punctures. This will help save the superficial veins for infusions. Analysis of the daily urine output of sodium and potassium often is of aid in determining the daily requirement of these important ions. For instance, 120 mEq. of K^+ were necessary daily to maintain the patient with a normal potassium concentration during a two week pe-

* The gamma globulin is given suspended in 500 ml. of saline solution. It is commercially available through Parke, Davis & Company and Cutter Laboratories. The package insert reads "do not give by the intravenous route."

TABLE 6—*Evans' Rule for Burns*

FIRST DAY (24 HOURS)	GIVE MOST IN FIRST 12 HOURS
Baseline	2000 cc. 5% Dextrose in Water
plus	
1 cc. of Plasma or Substitute (or ½ cc. Blood and ½ cc. Plasma) for each 1% Burn per kilo	
and	
1 cc. of Electrolyte Solution (0.9% Saline or ⅔ Saline and ⅓ $NaHCO_3$) for each 1% Burn per kilo	
SECOND DAY (24 HOURS)	
Baseline	2000 cc. 5% Dextrose in Water
plus	
½ cc. Plasma or Substitute per 1% Burn per kilo	
and	
½ cc. Electrolyte Solution per 1% Burn per kilo	

riod when he was receiving cortisone.* A simple determination that will be of great help in determining nutritional requirements is a daily record of caloric intake. If the patient is not able to take at least 2,500 calories per day by mouth a rubber stomach tube will allow him to receive high protein caloric supplements. Blood and plasma should be given as needed. It is particularly important to achieve a level of 6 gm. % of plasma protein since this seems to be the *sine qua non* of good skin graft take.[2] During the four-month period the patient received 31 transfusions of whole blood and 93 units of plasma in order to help maintain hemoglobin and protein concentrations at a normal level.

7. Initial care of shock and fluid requirements should follow a well codified plan:

This vital point has been left for last because it has been so well publicized and accepted.[3] Table 6 shows an acceptable program for the first 48 hours as suggested by Evans.[13] After the initial period, fluids and electrolytes should be determined by accurate estimates of loss through exudation and the urine, and by chemical determinations. In addition, it is our feeling that a large urine output may be helpful in ridding the patient of burn toxin, so if the patient is young and has a good cardiovascular system we strive for a urine output of between 3,000 and 4,000 ml. per day.

Discussion

This presentation of an aggressive and eclectic method of the medical management of severe burns is justified by the continued high mortality in this group of patients.[1] Unquestionably, some patients with burns will do well with a less aggressive therapeutic program, but we are hopeful that the clinician faced with a burn patient who may not be making satisfactory progress will find some points of guidance in the material that has been offered.

It should be mentioned that a minimal amount of sedation and pain medications should be used throughout the patient's course since if all the surgical and medical measures being used are controlling the fundamental problems, the patient should be comfortable during the major portion of his illness. Finally, the use of tetanus toxoid and gas gangrene antitoxin must remain part of the routine management of burn patients since tetanus and gas gangrene still occasionally occur in spite of antibiotic therapy.

Summary

The following aphorisms concerning the medical management of severe burns are presented and discussed:

1. Care of a severe burn is a team affair.
2. Bacterial invasion must be aggressively fought to the extent that the patient is essentially afebrile and has no areas of pus. Maximum tolerated dosages of antibiotics should be used both parenterally and locally.
3. Eclecticism must be the order of the day.
4. Guard that vein.
5. When progress is not satisfactory, search for the cause and change therapy to rectify it.
6. Normal nutritional and chemical status must be maintained.
7. Initial care of shock and fluid balance should follow a codified plan.

561 North 15th Street (3).

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The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin.

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NOTE: The January Blue Book issue of the Wisconsin Medical Journal is a handy reference on medico-legal subjects. Keep this issue and refer to it often.

Bilateral Renal Vein Thrombosis

By AARON H. LIPTON, M.D., and DAVID J. CARLSON, M.D.

Milwaukee, Wisconsin

THIS CASE is presented because of the unusual and uncommon finding of massive bilateral renal vein thrombosis in a 60-year-old white woman. This malady was originally described in 1840 by P. Rayer.[1] He reported seven cases of renal vein thrombosis, two of which had the nephrotic syndrome. Since then only scattered reports of bilateral renal vein thrombosis have appeared. The first report in the English literature was in 1939.[2] Less than 300 cases have been reported in the literature.

The majority of cases has been found in infants. Several of the adults also had the nephrotic syndrome. Although mortality is high, Shattock[3] reported a case of bilateral renal vein thrombosis proved at autopsy 25 years after the acute disease. In this case thrombosis apparently occurred during or after a foot race in which the individual held his breath during the race that lasted 15 seconds. Immediately after the race, the patient complained of severe pain in the lumbar spine. He was ordered to bed where he remained for six months. Albuminuria appeared shortly after the event and persisted throughout life. In almost all instances the diagnosis has been made at autopsy rather than clinically.[4]

Case Report

A 60-year-old white woman was admitted to the hospital on Dec. 9, 1960, with terminal carcinomatosis from adenocarcinoma of the left breast. The patient had had a radical left mastectomy in 1955. She was quite well until three months prior to admission at which time she noted pain in the chest on the left side and in the right hip radiating down the right leg. She also complained of recent nausea, vomiting, and some shortness of breath. There was no history of allergic reactions.

She was a well developed, chronically ill, white woman who was mentally sluggish and slightly confused. Her blood pressure was 160/88, pulse 84 per minute and regular, and respirations 20 per minute and regular. She was markedly dehydrated. Decreased resonance over the right base, decreased breath sounds and a few basilar rales bilaterally were noted. There were no cardiac murmurs, irregularities, or enlargement. The left breast had been surgically removed leaving a long, transverse, curved, well healed scar. The liver extended 2 cm. below the right costal margin in the midclavicular line, and it was moderately tender. Active bowel sounds were present. Her deep tendon reflexes were decreased in the right leg. There were no abnormal reflexes. She had moderate tenderness over the dorsal spine and over the chest on the left side posteriorly.

The working diagnoses were: metastatic carcinoma, pleural effusion on the right and possible vertebral involvement.

The urine specific gravity was 1.011; it contained 50 mg. of albumin per 100 ml., an occasional white blood cell per high-power field and many red blood cells per high-power field, no sugar or acetone. She had several normal white and differential blood counts. The hemoglobin values were in the low normal range except on Jan. 9, 1961, when the hemoglobin level dropped suddenly to 7.9 gm. per 100 ml. At this time slight stippling of the erythrocytes, moderate anisocytosis, and macrocytosis were noted. The blood urea nitrogen rose from 32 mg. per 100 ml. to 46 mg. per 100 ml. in one month. The erythrocyte sedimentation rate on admission was 41 ml. per hour. Total protein was 7.14 mg. per 100 ml. with albumin 3.53 and globulin 3.61; transaminase (SGOT) 29 units; alkaline phosphatase 22 King-Armstrong units. The serum sodium level was 135 mEq./l., potassium 3.4 mEq./l., chlorides 94 mEq./l. and total carbon dioxide concentration 29.5 mEq./l., pH 7.43.

Doctor Lipton is a second year resident in pathology at the Veterans Administration Hospital, Wood. The case reported was discovered while Doctor Lipton was on rotation to the Milwaukee Hospital, Milwaukee.

In x-ray films of the bones evidence of metastatic carcinoma involving the pelvis, hips, and second cervical vertebra was seen. The electrocardiogram had nonspecific changes suggestive of myocardial fibrosis or hypopotassemia.

She was given analgesics and x-ray therapy to the hips and pelvis for metastatic disease. Genitourinary antiseptics and steroids also were used.

Approximately two weeks after admission, pain in the urinary bladder developed and she had varying degrees of urinary retention. This was considered as possibly related to involvement of the distal spinal cord by metastatic tumor. On Jan. 8, 1961, the blood pressure suddenly dropped to 70/0, the pulse rate increased to 140 per minute. The patient became lethargic and developed Cheyne-Stokes respirations. Her subsequent course was ingravescent and she died quietly on Jan. 21, 1961.

Significant Autopsy Findings

The left kidney weighed 135 gm., the right 150 gm. Externally they were not unusual. The renal arteries were patent. Both renal veins were enlarged to 2 cm. in diameter. Each was completely filled with a well organized thrombus. The thrombi were laminated, gray-white, and interspersed with reddish-purple areas. Organized thrombi were present throughout the larger venous structures within the kidney; the interlobar, arcuate, and interlobular veins as well as the main branches of the renal vein. The pyramids and medullary rays were poorly demarcated. Two 0.5 cm. metastatic tumors were found in the liver parenchyma. This type of tissue completely replaced the marrow of the tenth and eleventh thoracic vertebrae. She also had bronchopneumonia, acinar dilatation of the pancreas; focal, acute, and chronic pancreatic necrosis, and squamous metaplasia of the pancreatic ducts. All viscera were moderately congested.

The microscopic examination was reported as follows: The cortex of the kidneys was thin and well preserved. Throughout the parenchyma were many hyalinized glomeruli with no particular pattern. The remaining glomeruli were well preserved and not remarkable. The distal convoluted tubules on the whole were well preserved and not remarkable. A few contained deep orange, amorphous casts. The most pronounced change was within the renal veins. They were filled with large antemortem clots moderately well organized. Thrombi were found within the interlobular, arcuate, and interlobar, as well as major branches of the renal vein. Organization was most advanced within the renal vein itself. Organization was less pronounced in the distal interlobular and arcuate veins. Small arterioles, for the most part, were thin-walled and not remarkable. The calyces and pelves were lined by normal transitional epithelium. Thrombosis and organization in the left kidney appeared to be of longer duration than in the right. Organization was variable ranging from fairly firm fibrous connective tissue to a loose and acellular amorphous mass.

Discussion

This patient's bilateral renal vein thrombosis was not diagnosed antemortem. There was a minimum of evidence pointing to kidney involvement. Her urinary output was low; the specific gravity of the urine was somewhat low. In some of the specimens of urine many erythrocytes were found, but later in the course of her hospital stay the specimens were free from erythrocytes. The albuminuria was mild. All of these abnormalities could have been attributed to the terminal state in a person with carcinomatosis. They did not justify a diagnosis of severe renal disease.

Several features of the postmortem examination are worthy of note. The thromboses were entirely confined to the renal veins and did not extend into the inferior vena cava. The renal parenchyma was well preserved; glomerular changes, tubular and arterial lesions were minimal.

In most previously reported cases, the venous thrombosis usually began in the more distal smaller venous channels and progressed medially to the inferior vena cava. In this patient the degree of organization was more pronounced in the medial renal veins and less pronounced in the more distal arcuate and interlobular veins indicative of progression peripherally rather than medially.

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(Continued on page 483)

Ovarian Teratoma (Struma Ovarii) (Ovarian Goiter)

By ARTHUR R. WEIHE, M.D., MARTIN L. JANSSEN, M.D.,
Adams, Wiscansin

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Beaver Dam, Wiscansin

A TERATOMA is a neoplasm composed of multiple tissues foreign to the part in which it arises. In order of frequency teratomas arise in the ovaries, testes, anterior mediastinum, retroperitoneal space, presacral and coccygeal region. Rarely they arise at the base of the skull, brain, pineal gland, neck and abdominal viscera.

Ovarian Teratomas

Ovarian teratomas outnumber all others combined. The most common synonym is "dermoid cyst of the ovary." The mean age for occurrence is around 30 years. They have been described in children under 20 months old and in women over 68 years of age. Malignant varieties are seen principally in children and young adults.

The presenting symptoms may be simply those of a palpable ovarian mass or the tumor may be an incidental finding during other abdominal surgery. At times the patient may present the symptoms of an acute abdomen, and a twisted tumor with strangulation of blood supply is found. The malignant varieties have symptomatology related to rapid growth, invasion and metastasis. Ovarian teratomas are usually single but may be multiple and bilateral.

The most common tumor is benign, polycystic and contains large quantities of sebaceous material and hair. It usually has a hard plate of tissue somewhere on the inner wall of the main cyst composed of bone and/or cartilage and well formed teeth are often present. Skin is readily recognizable in the same area. Microscopically any embryonic, fetal or adult tissue may be seen. All three germ layers are usually represented. Besides skin and its accessory structures, teeth, nervous tissue, smooth muscle, bone, cartilage, respiratory epithelium and intestinal glands are very often noted. Liver, pancreas, thyroid and renal tissue are seen less frequently.

Struma Ovarii

Thyroid tissue is occasionally seen in ovarian teratomas. Rarely the bulk of the tumor consists of thyroid tissue and may resemble a nodular goiter and has been referred to as "ovarian goiter, struma ovarii, ectopic thyroid tissue of the ovary, and thyroid tumor of the ovary." Meticulous microscopic examination of many sections will nearly always prove their origin from ovarian teratomas.

Case Presentation

In May, 1959, a 68-year-old white woman presented herself for a physical examination. She had no specific complaints except for 15-pound weight gain.

She had always enjoyed good health. Her menses began at age 16 and she was a gravida I, para I. She had an uneventful menopause. At age 58 she had a cystocele and rectocele repaired. There was no history of goiter or other thyroid disorder.

Her father died of old age at 87 years. Her mother died of a hernia condition at 58 years. She has two sisters who are living and well.

The patient was born in Bodenmaes, Bavaria, on Dec. 7, 1879. This was a mountainous area where the main occupations were

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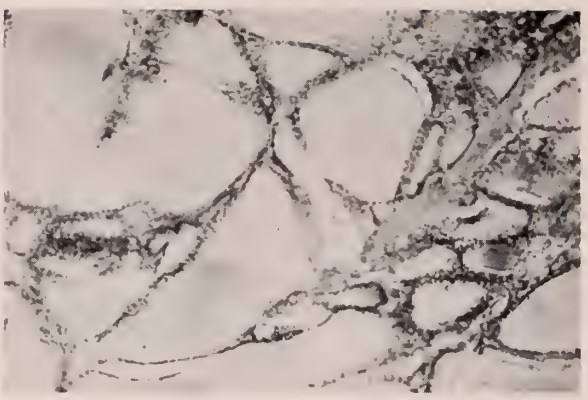

Fig. 1—Photomicrograph of a section from the ovary showing typical thyroid follicles containing colloid material.

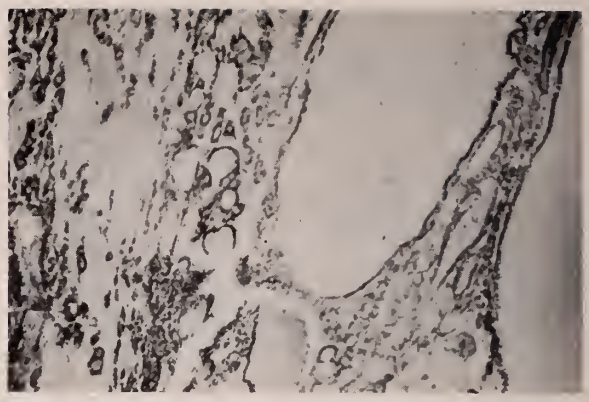

Fig. 2—Photomicrograph of another section of the ovarian teratoma showing micro- and macrofollicles typical of a nodular goiter.

forestry and mining for sulphur and mercury. Nodular goiter was endemic in this area for generations and the patient stated that the men wore long beards and the women wore special clothing to hide the disfiguring growths in their necks. This was a local phenomenon and to her knowledge was the only area in Bavaria where this was a community malady. Her husband came from a village approximately 35 miles away in an adjacent valley where goiter was practically unknown. When the patient was 13 years old, the government became aware of the local situation and the people of the entire area were examined by state physicians. An emergency hospital was set up and hundreds of goiters were removed from all but the most elderly people. There was a compulsory closure of all wells, and water was then brought down from the mountains. This venture was so successful that the area has now become a spa and the citizens pay no taxes. Goiter is no longer a problem in the area.

The patient was a slightly obese but otherwise normal-appearing white woman weighing 150 pounds. Examination of her eyes, ears, nose and throat was negative. Her blood pressure was 170/80 and the heart was normal in size, rate and rhythm. The chest and lungs were normal. Examination of the abdomen revealed no masses, scars or tenderness but an umbilical hernia was present. Vaginal examination was difficult but there was a general impression of the presence of a pelvic mass. The rectal and neuromuscular examinations were negative. Cytology smears of the cervix and vagina were normal. The hemoglobin was 14.0 gm. per 100 ml.; hematocrit reading 46%; white blood cell count 8,100 per cu. mm. with a normal differential.

On March 4, 1961, she returned with a complaint of pain in the mid-abdomen of three days' duration. On examination the umbilical hernia previously noted was discolored blue and was tender. It measured 3 cm. in diameter. A diagnosis of incarcerated hernia was made and an operation was performed on March 6, 1961. The hernial sac was removed and found to be empty, having apparently reduced itself spontaneously at surgery. Exploration of the pelvis disclosed a large, irregular, lobulated tumor in the region of the right ovary. It was firm, encapsulated, smooth and grayish-purple and replaced the right ovary completely. The pedicle was clamped and the mass removed. The appendix was also excised and the usual closure made. Postoperatively the patient's course was uneventful.

Gross and Microscopic Pathology

The surgical specimen consisted of a formaldehyde (Formalin)-fixed right ovary which was large, irregular, lobulated and measured 10 × 7.2 × 5.2 cm. Externally it was smooth but lobulated and grayish-purple to yellow. On cross section multiple cystic areas were noted. The cysts varied in size and content with some containing chocolate-brown, firm, gelatinous material and others containing a grayish-tan to yellow colloid-like substance. The cyst walls varied in thickness from 1 to 6 mm. and presented a honeycombed appearance in some areas. One small cyst contained a pasty, yellow, sebaceous-like material. Microscopic examination of multiple sections from various areas of the tumor revealed only thyroid tissue. The histologic appearance was that of a typical nodular goiter with marked variation in size of the

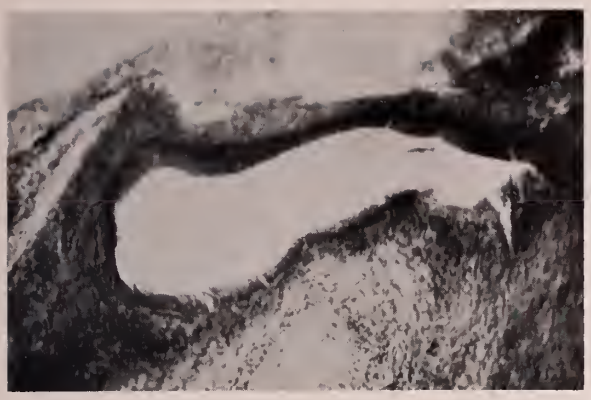

Fig. 3—Photomicrograph of a section from the hilus of the teratoma demonstrating a small cystic follicle and proving the ovarian origin of the tumor.

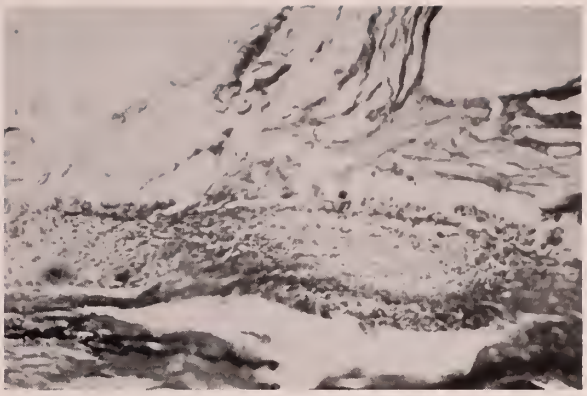

Fig. 4—Photomicrograph of a sebaceous cyst within the ovarian teratoma. Note the sebaceous material in the lumen of the cyst in the upper portion of the photograph.

thyroid follicles and areas of hemorrhage, fibrosis and calcification (Figures 1 & 2). Multiple additional sections of tissue were taken from the point of attachment of the tumor and ovarian tissue was demonstrated (Figure 3). One section demonstrating the wall of a sebaceous cyst proved the teratomatous origin of the tumor (Figure 4).

Discussion

The profusion of names attached to teratomas because of their structural components is deplored by most authorities. When a diagnosis of ovarian teratoma is made, it is best to designate it as such and then place in parenthesis the term describing the dominating structural component if there is one. In the case presented the diagnosis will properly be "ovarian teratoma (struma ovarii)." The term "dermoid cyst of the ovary" is best discarded as dermoid relates to other lesions not related to teratomas and also implies an origin from only one germ layer. Most teratomas have all three germ layers represented.

The main concern of the surgeon is whether the tumor is benign or malignant. The majority of ovarian teratomas are benign. Occasionally a squamous cell carcinoma will arise from the skin in a previously benign cystic teratoma of the ovary. Even rarer is the adenocarcinoma arising from a glandular component and the argentaffinoma (carcinoid) arising from an intestinal component. Simple excision is adequate therapy for the benign group and the occasional tumor showing an area of malignant change in an otherwise benign lesion with no evidence of local spread.

In the case presented thyroid tissue was predominant in a teratoma of the right ovary. The question arises as to whether the predominance of thyroid tissue with the development of a nodular goiter-like lesion in this teratoma could have been influenced by the fact that the patient has lived in both an epidemic and an endemic goiter belt. The ovarian tumor had obviously been present for a long time. Could an iodine deficiency have influenced the one-sided development of this benign teratoma of the ovary?

Summary

A case of ovarian teratoma with thyroid tissue as the main structural component is presented. "Ovarian teratoma" is emphasized as the correct terminology, and nomenclature by structural component is relegated to a descriptive parenthesis (struma ovarii). The importance of meticulous examination of numerous sections to prove the teratomatous origin of this tumor is pointed out. The possible relationship of the goiter-like overgrowth in this teratoma and the patient's residence in epidemic and endemic goiter belts is considered.

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Fire Safety in Hospitals

By D. J. JENNERJOHN

Madison, Wisconsin

THE HOSPITAL, above all other public service institutions, is one place in which the average individual gives little thought to potential danger from fire. He is trained to observe protective measures at school and at work and is usually alert to the risk and danger of fire or panic. His entry into a hospital, however, is associated with injury or illness to himself, his family, or his friends, and all his concern is wrapped around his personal problems. Consequently, he has little interest left for the basic precautions which he might otherwise observe.

Yet, today, the situation with regard to fire safety in hospitals is far from ideal. Data on fires at hospitals and similar institutions show that we have about one a day in this country. The result is untold pain and suffering and an annual property loss of millions of dollars.

Immediately following any hospital fire serious enough to merit nationwide publicity, local authorities and individuals become apprehensive for the safety of the institutions in their own communities. At such times they become acutely aware of their own problems relating to fire safety.

It is difficult to assign a definite cause for many hospital fires. Some of the disasters occur in old buildings of inferior construction. Some may be due to improper installation or operation of equipment. Others are undoubtedly caused by poor housekeeping. While it may be impossible to eliminate all hazard with regard to hospital functions, localizing and minimizing the effect of such dangers by insisting on completely fire-safe construction is readily possible.

The Wisconsin State Board of Health, under its authority governing maternity hospitals and homes, has attempted to prevent a disastrous hospital fire in Wisconsin by requiring a nonfire-resistive hospital of more than one story to install an approved automatic sprinkler system. Further regulations having to do with evacuation and disaster plans, smoking, materials of construction, fire extinguishers, etc. are also included in the Board's rules.

Each hospital is encouraged to undertake periodic surveys and consultation with local and state fire officials and insurance company safety engineers. Such a survey can reveal many difficulties resulting from maintenance and operation as well as construction details and exit facilities—things that are inherently wrong but pass unnoticed in day-to-day activity.

The practice of fire safety begins in the architect's office. This fact cannot be stressed too strongly. Unless adequate fire safety is incorporated in the original planning and design stage of a building, it may never be fully achieved. The cost of installing safety features, although relatively minor at the time of construction of the building, may be so prohibitive at a later date as to permit only partial compliance with generally accepted standards.

In essence, the basic principles of fire safety as applied to the design of buildings include three functions: (1) planning and construction of the building so as to minimize the chance of fires starting or spreading beyond the point of origin; (2) planning for sufficient and adequate exit facilities so that occupants can be rapidly and safely evacuated if the need arises; (3) planning for the prompt discovery and announcement of fires and for the necessary facilities to extinguish them. The degree of safety achieved is entirely dependent upon the extent to which these conditions are realized.

Mr. Jennerjohn is a registered professional engineer, Division of Hospitals and Related Services, Wisconsin State Board of Health, Madison.

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COMMENTS ON TREATMENT

Toxicity of the Phenothiazines

By F. E. SHIDEMAN, M. D.
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THAT A BRIEF review of the untoward effects which have been encountered with the phenothiazine "tranquilizers" might serve a useful purpose was suggested by a recent inquiry from a senior medical student regarding the toxicity of prochlorperazine (Compazine). Certainly one should be aware of the potential hazards of such widely and commonly employed drugs and our experience with this group of compounds only lends support to that aphorism of my predecessor, "There is no such a thing as a nontoxic drug." The promise of nonserious toxicity of chlorpromazine on long-term administration suggested by Ayd's report in the *Journal of the American Medical Association* in 1959 has not been borne out by subsequent experience. The early belief that removal of chlorine from the chlorpromazine molecule would result in a compound with significantly less hepatotoxicity is doubtful. It occurs all too often with promazine (Sparine). Although there was not a large number of potentially serious complications listed for the phenothiazine drugs in the *Bulletin of the Psychopharmacology Service Center* for June 1960, the tabulation of nonserious side effects which occur relatively frequently showed these to be not uncommon.

Most of the phenothiazines produce some sedation. It usually is not severe but people may become sleepy and even very drowsy. Sudden hypotension has been noted and patients may complain of feeling cold, may overeat and gain weight and experience certain endocrine changes, e. g. development of gynecomastia, skipped menstrual periods, occasional lactation. These reactions are not too common but they do occur. Skin rashes, itching and photosensitivity may be seen and so-called atropine-like reactions with mepazine and prochlorperazine, associated with clonic convulsions and hyperthermia, have been recorded. Not infrequently a patient exhibiting photosensitivity when on one compound may be changed to another and go into the sunlight with impunity. Mental changes which cannot be tolerated may be encountered. Patients become confused, agitated and refuse to take the drug.

One of the potentially serious complications of phenothiazine therapy is hepatotoxicity. Presently available information indicates that jaundice occurs in less than one per cent, probably nearer 0.5 per cent, of those individuals who receive chlorpromazine. As indicated previously, its occurrence with promazine, and this also applies to mepazine (Pacatal), is all too frequent. With prochlorperazine (Compazine) it is relatively rare and, to the best of my knowledge, it has occurred in less than ten of the thousands or millions of people who have received this drug. On the basis of presently available information, thiopropozate (Dartal) and perphenazine (Trilafon) are fairly safe insofar as jaundice is concerned. Jaundice probably has as its basis an allergic mechanism in which a metabolic product or products cause edema and congestion along the small bile canaliculi. Usually it lasts only a week or two but some patients have continued to have jaundice for months and some deaths have occurred, usually in patients with previously severe liver dysfunction. Jaundice is most likely to occur between the fourth day and fifth week of drug administration. It is rare in the case of trifluoperazine (Stelazine) and fluphenazine (Permitil, Prolixin), the dosages of which are low. Perhaps it is associated with the total dose of the phenothiazine employed, and hence the less total drug one gives the less is the possibility that jaundice will occur.

Hematologic changes may portend serious consequences during phenothiazine administration. Agranulocytosis and other blood dyscrasias have been stated to occur in about one in every 50,000 individuals receiving chlorpromazine. On the basis of reports received by the Council on Drugs the phenothiazines contribute significantly to the total number of agents or preparations with which significant alterations in the blood picture are associated. A summary of these data are presented in the following table.

TABLE 1—*Incidence of Hematologic Changes Following Therapy with Phenothiazine Derivatives**

	Pancytopenia	Thrombocytopenia	Leukopenia	Anemia	Total
Total Cases Reported**	130	64	179	28	401
Chlorpromazine	1	1	53	2	57
Mepazine	2		11		13
Methylpromazine			1		1
Prochlorperazine			2		2
Promazine			21	1	22
Thioridazine		2			2
Trifluoperazine	1		1		2
Triflupromazine			1		1
Total Phenothiazines	4 (3%)	3 (5%)	90 (50%)	3 (11%)	100 (25%)

*Compiled from semi-annual tabulation of reports submitted to the Registry on Blood Dyscrasias, Council on Drugs, American Medical Association, January, 1961.

**Includes only data on drugs where there was no history of other drug administration for 6 months prior to onset of hematologic change. Cases are compiled from information on 94 drugs, drug groups or toxic substances.

Although a causal relationship between the administration of any of these drugs and occurrence of hematologic change can not be established, it is interesting to note that the phenothiazines represent only about 9 per cent of the drugs tabulated, yet they were associated with 50 per cent of all the cases of leukopenia reported and 25 per cent of all cases displaying some abnormal alteration of the formed elements of the blood.

One of the more recently observed side effects produced by the phenothiazines is the extrapyramidal syndrome. It has been reported after administration of a number of these compounds and has been considered a potentially serious complication with trifluoperazine (Stelazine). It was found to be the most common side effect in a series of patients receiving fluphenazine and reported on by Wachsmuth. Smith and Miller have seen it with perphenazine. Prochlorperazine and trifluoperazine are more likely to give rise to extrapyramidal symptoms than is chlorpromazine. The syndrome may be manifested merely by motor restlessness, particularly at the lower levels of dosage, but at high dose levels dystonias and signs resembling Parkinsonism may occur. The newer, more potent compounds are more prone to produce the extrapyramidal syndrome than are the older less potent ones. With smaller doses this side effect may persist no longer than 4 hours but if the dose has been very large it may last 24 to 48 hours. Usually little more than reassurance is required since the condition usually is self-limiting. Supportive measures may be in order, and the antiparkinson drugs and barbiturates have proved useful. Recently Smith and Miller have been able to promptly terminate this condition, which was caused by perphenazine, by the intravenous administration of 25 mg. of diphenhydramine.

DIVERTICULITIS OF THE COLON

GORDON A. DONALDSON, M.D., Boston, Mass. Excerpt from *Journal of the Michigan State Medical Society*, July 1961, page 887.

The drastic changes that have taken place in the management of diverticulitis of the colon in the past twenty years are due to several factors. Greater longevity has increased its frequency in the population, its natural history is now better understood, there is greater appreciation of the seriousness of its complications, and finally, there has been a steady lowering of the operative mortality and morbidity resulting in more effective surgical treatment. Approximately 70 per cent of those patients hospitalized for this disease may be successfully treated by medical measures. In about two-thirds of those patients subjected to surgery today, the operation is necessary for the treatment of one of the several complications of diverticulitis—perforation, fistula, obstruction, or hemorrhage. There is some increase in the relative frequency of operation for the uncomplicated primary disease of diverticulitis—often a difficult decision to make. As a corollary to this, it is becoming increasingly feasible to resect the diseased area and perform the anastomosis in one stage. The value of a protective complementary transverse colostomy in those cases where there is any question of the competency of the suture line in the bowel cannot be over-emphasized. Surgery for diverticulitis of the colon and its complications can now be done with about as great a degree of safety as for any other type of bowel disease. And the long-term results following successful resection of the sigmoid for diverticulitis are excellent.

Sponsored by Section on Pathology
State Medical Society of Wisconsin

CLINICOPATHOLOGIC CONFERENCE

Guest Editor: P. C. DIETZ, M.D.
La Crosse, Wisconsin

CASE PRESENTATION*

Dr. M. Torres (Intern): A 74-year-old white man had called a physician to his home at noon during December 1960 because of malaise, sore throat, cough and fever of two days' duration. The oral temperature was 101.8 F. Pharyngeal injection and subcrepitant rales in both lung bases were noted. He was given an intramuscular injection of penicillin. On the same day, after the evening meal at home, he walked into his bedroom and collapsed on the bed. There the physician found him semicomatose but able to move all extremities albeit the left upper extremity less vigorously. In the hospital the patient's initial blood pressure was 150/88 and his rectal temperature was 104 F. He was moderately obese. Respirations were noisy and rapid and he appeared cyanotic. He moved his extremities, vomited, and was involuntary. There was no exophthalmus. Pupils were equal and reacted to light and there was horizontal nystagmus with right deviation. Diffuse puffiness of the soft tissues of the neck was noted but the thyroid was not enlarged or nodular. There was dilatation and engorgement of facial, neck, upper extremity, anterior thoracic and anterior-superior abdominal veins, those on the left side of the neck and left shoulder and arm being slightly more prominent than those contralaterally. The heart was enlarged to the left anterior axillary line; no murmur was heard; the rhythm was irregular. Moist rales were heard over the right lung base and the entire left lung field. The abdominal wall was moderately protuberant. The liver edge was palpated 5 cm. below the right costal margin. There was no enlargement of the spleen, no hernia and there was no abdominal tenderness. Edema and jaundice were absent. Deep tendon reflexes were bilaterally active and equal. The Babinski sign was questionably present on the left. Clonus was absent. The hemoglobin was 11.9 gm. per 100 ml., the white blood cell count was 20,500 with segmented cells 72%, band forms 23%, lymphocytes 2%, and monocytes 3%. A catheterized urine specimen had a specific gravity of 1.020 and revealed 2+ albumin, an absence of sugar, one white blood cell, 15 red blood cells and 3 fine granular casts per high-power field. The prothrombin activity was 45%. A syphilis (VDRL) test was nonreactive. The electrocardiogram revealed auricular fibrillation. A chest x-ray film taken with the bedside unit revealed patchy areas of increased density at the right base medially and at the left base in a retrocardiac location, findings which were believed to be consistent with pneumonia. Initially he appeared to be attempting nonvocal response to stimulation, but coma supervened within hours. Tracheal mucus accumulated, laryngeal stridor and Cheyne–Stokes respirations ensued. The temperature receded to 99.8 F. but the blood pressure rose steadily to an ultimate 215/96. Therapy consisted of parenteral fluids, penicillin, chloramphenicol, digitalis and anticoagulants. He died 28 hours after admission to the hospital.

The past record of the patient disclosed that appendectomy and left inguinal hernia repair had been performed at the age of 25 years. A transurethral prostatic resection was done for benign hyperplasia at the age of 70 years but this was followed after several months by frequency and nocturia. In 1955, when 68 years old, he had presented himself to a hospital elsewhere because of dull persistent pain in the left side of the neck, left axilla and the anterior chest wall which he had had for one week, and painful cervical masses present for three days. He had not lost weight and had had no cough, ankle edema or deep chest pain. The patient smoked approximately one-half pack of cigarettes daily and consumed alcohol moderately. At that time his blood pressure was 140/100, his pulse rate 82 (regular) and his temperature was normal. He appeared well nourished. The masses about the neck were soft, fluctuant, somewhat tender, well delineated, 2 to 3 mm. in size, and were associated with prominent cervical veins even when the patient was in the sitting position. There were dilated, engorged veins over the eyebrows, neck, both brachial regions, the anterior chest and superior anterior abdominal wall. Veins of the forearms and hands were prominent but not markedly dilated. The venous pattern of the chest and upper abdominal wall was most prominent when he was in the sitting position, the blood flow being caudad. The neck and arm veins were most prominent when he was supine. Those of the forearms and hands maintained their prominence on elevation of the extremities. The onset of this venous dilatation had occurred 20 years earlier, had been gradual and painless, and he could not recall a serious associated illness. A few discrete, tender left axillary nodules were palpable. There was no abdominal tenderness or hepatosplenomegaly. Rectal examination revealed no hemorrhoids. The prostate presented Grade 2 symmetrical enlargement. A serologic test for syphilis was negative. The hemoglobin was 12.5 gm. per 100 ml. and the white blood cell

*From St. Francis Hospital, La Crosse.

count was 11,850 with a normal differential count. The urine had a specific gravity of 1.022 and contained 2+ albumin with 3 to 4 hyaline and occasional granular casts and 5 to 6 white blood cells and 2 to 4 red blood cells per high-power field. The 30-minute serum bilirubin level was 0.65 mg. per 100 ml. and the serum cholesterol was 180 mg. per 100 ml. The serum alkaline phosphatase was 3.1 Bodansky units, the cephalin cholesterol flocculation and thymol turbidity were negative and 1.7% retention of sulfobromophalein sodium was found. A Lee–White coagulation time and the prothrombin activity were normal. A chest x-ray film revealed a cardiac silhouette of normal transverse diameter, moderate fusiform widening and calcification of the aortic arch, minimal blunting of the left costophrenic sulcus and otherwise clear lung fields. Apical lordotic views and planograms of the chest revealed no evidence of infiltration, cavitation or consolidation. Chest films with barium swallow revealed no evidence of displacement or constriction of the esophagus. An electrocardiogram was suggestive of a previous posterior wall infarct. Bronchoscopy and bronchial cell studies were not abnormal. A radioactive iodine (I^{131}) uptake and scintigram were considered within normal limits. Venous pressure determinations were: right arm 186 mm. of water resting, 370 mm. upon right upper quadrant pressure; left arm 238 mm. resting, 274 mm. upon right upper quadrant pressure; right femoral vein 40 mm. Arm to tongue (dehydrocholic acid [Decholin]) circulation time was 46 seconds and arm to lung (ether) time 38 seconds. Biopsy of a left axillary nodule was reported as axillary vein branch thrombosis. No other biopsy was performed.

Following this study in 1955, long-term anticoagulant therapy was decided upon as the only necessary treatment and administration of bishydroxycoumarin (Dicumarol) was begun. The cervical masses disappeared and his symptoms cleared, although the venous engorgement persisted unchanged. He was able to resume his avocation as a retired person of modest means, namely that of leisurely travel about the country. He was without medical supervision from 1955 until two months prior to his final admission when he visited a local physician stating he had experienced moderate, progressive dyspnea upon exertion during the past five years but no chest pain, palpitation, numbness of fingers or ankle edema. He had experienced no headache, drowsiness, confusion, hoarseness or dysphagia. He had been able to walk and perform usual tasks normally at a slow pace. His chest and neck veins had enlarged during the past three years although they had been prominent continually since he was approximately 48 years old. He was well nourished, stocky, and oriented as to time and place but was moderately senile in behavior and memory. Lenticular opacities made funduscopic examination unsatisfactory, but it was believed to disclose no gross abnormality except for increase in diameter of veins. No neck nodes or masses were felt at this time. The brachial blood pressure was recorded as 150/80 on the right, 152/90 on the left. Heart rate and rhythm were normal and no murmur was heard. A chest x-ray film obtained several weeks later revealed no mediastinal widening and no active pulmonary disease.

Clinical Discussion

Dr. R. A. Pribek: The case record for discussion today concerns a 74-year-old retired white man who entered the hospital with an acute febrile respiratory illness and died a day later. The clinical picture and the roentgenograms made during his last hospital stay were consistent with a diagnosis of pneumonia, and that disease was in all likelihood the cause of his death. Prior to the onset of this acute illness he had traveled about for an amazingly long time with abundant evidence of chest disease without being incapacitated. When he was 68 years old, he entered a hospital because of pain in the left side of his neck and thorax. At this time he was found to have a prominent venous pattern in the neck, arms, thorax and upper portion of the abdomen which had been present for 20 years. It was associated with venous hypertension in the upper extremities in the presence of normal venous pressure in the lower extremities. During that hospital stay, the patient had an extensive diagnostic study; but so far as I can determine from the protocol, the exact etiology of this superficial venous abnormality was not determined. I am at a loss to explain the cervical adenopathy which he had at that time. Perhaps this was not an enlargement of lymph nodes at all. The pathologist was unable to supply any additional information, since the biopsy he received from the left axilla revealed an axillary vein branch thrombosis. The patient was placed on long-term anticoagulant therapy following this study and was discharged from the hospital when he felt improved. A physician saw him two months prior to his last admission at which time he was found to be in relatively good health except that the dilated venous pattern in the neck, arms, shoulders, anterior thoracic and upper abdominal walls was still present.

It seems that a diagnosis of superior vena cava syndrome was made five years prior to the patient's last hospital admission. If the information in the protocol is correct, he had had the syndrome for at least 25 years before he died.

The superior vena cava syndrome was first described in 1757 by William Hunter. It can be produced by any lesion which compresses the superior vena cava from without or any lesion which invades the vena cava and leads to thrombus formation. The syndrome is also produced by bilateral thrombosis of the innominate veins and on rare occasions by a fistula between the superior vena cava and ascending aorta. The superior vena cava is abundantly surrounded by lymph nodes. With regard to these, suffice it to say that they drain the entire right lung, the mediastinum and the lower lobe of the left lung. Therefore, many lesions which occur in the lungs and mediastinum can result in enlargement of this group of nodes and thereby produce vena cava obstruction. What gave rise to such obstruction in the case under discussion? May I see the chest roentgenograms?

Dr. G. B. Ellenz (Radiologist): Two chest films were obtained in this hospital. One was on an outpatient basis several weeks before the final hospital admission. It reveals the heart to be left ventricular in type but normal in transverse diameter. There is mild ectasia of the aortic arch with a few calcific plaques in the arch portion. There is no aneurysm of the aorta. The lung fields are clear except for minimal fibrotic right peribronchial infiltration. In view of the protocol, it is significant that there is no demonstrable widening of the superior mediastinum or any indication of a mass about the superior vena cava. The second chest film was obtained with the portable unit at the bedside on the day after admission for the terminal illness. Here one notes patchy areas of consolidation at the right base medially and at the left base in a retrocardiac location, a finding which is strongly suggestive of pneumonia.

Dr. R. A. Pribek: In reviewing two excellent studies which have appeared in the literature, one notes that there has been a definite change in the etiology of the superior vena cava syndrome through the years. The authors of both studies believe the syndrome is increasing in incidence. The first is a most exhaustive and extensive study compiled by McIntire & Sykes[1] who reviewed 145 cases verified at autopsy or surgery and which included all cases through the year 1945. These authors found that 20% of cases were due to traction or compression by scar tissue or, in other words, to chronic mediastinitis, while primary intrathoracic tumors accounted for 33% and aortic aneurysms for 27% of the cases. The remaining 20% was a diversified group including such lesions as so-called idiopathic thrombosis of the superior vena cava, actinomycosis, constrictive pericarditis and benign tumors. A more recent review published in 1958 by Bruckner[2] consisted of 23 cases of which only 4.4% were due to traction or compression by scar tissue and 4.4% to aortic aneurysms, while 78.2% were caused by malignant intrathoracic tumors and the remaining 13% to assorted disease processes. Seventy per cent of the patients in this series and 78% of those with malignant tumors of the thorax who developed the superior vena cava syndrome had bronchogenic carcinoma. There were a few cases of lymphoma and, as in other series, an occasional teratoma and thymoma. Bruckner's finding of 70% bronchogenic carcinomas does not stand alone, for in another recent series published in 1956 by Calkins[3] 72% of tumors which produced the vena cava syndrome were bronchogenic carcinomas. Thus, there is a definite shift in etiology from the more benign lesions to malignant lesions and in particular to bronchogenic carcinoma. Today the chances are three out of four that when a male patient presents with the superior vena cava syndrome he has bronchogenic carcinoma. These figures are more significant when one considers that mediastinal widening is, according to a recent report,[4] caused by bronchogenic carcinoma in only 4% of patients in whom it is found and by malignant lymphoma in 20%. Bronchogenic carcinoma appears to be particularly prone to produce superior vena cava obstruction.

The diagnosis of the superior vena cava syndrome is usually not difficult. Ochsner & Dixon[5] considered the following constellation of signs pathognomonic: edema and cyanosis of the face, neck and upper extremities; venous hypertension in the arms with a normal venous pressure in the lower extremities; a dilated collateral venous system over the chest and upper abdomen. Prominent among the varied symptoms are headache, effort dyspnea, orthopnea and chest pain. The venous obstruction is worse when the patient is recumbent and therefore he frequently has great difficulty sleeping. Most patients are incapacitated and complain of constant weakness. A venogram is helpful in determining the level of obstruction and ex-

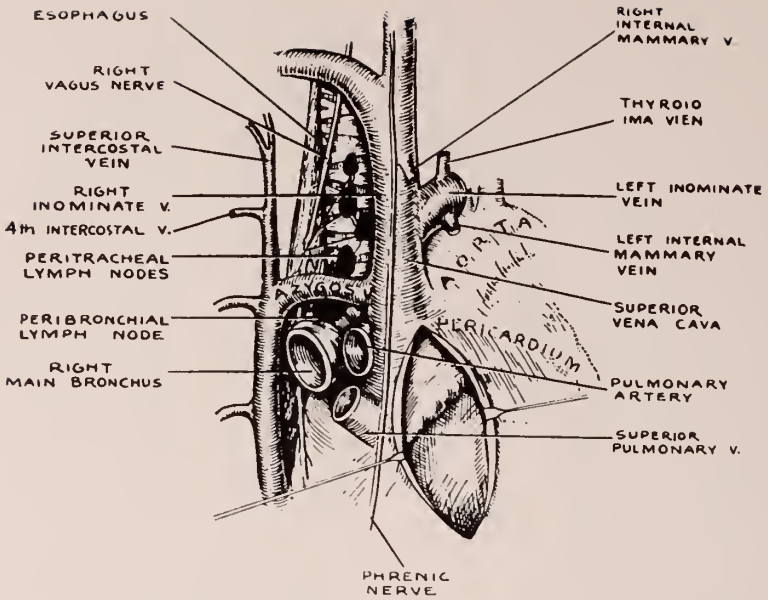

Fig. 1—Diagram of the normal right mediastinum showing the superior vena cava and adjacent structures. (Reproduced with permission from Klassen et al.[10])

tent of collaterals.[6] If the etiology of the syndrome is undetermined, an exploratory thoracotomy is advisable. The prognosis in the superior vena cava syndrome is poor, and understandably so, since at the present time the majority of patients have a malignancy which has spread to the mediastinum. On the other hand all reported series include a few patients who have lived a very long time with this problem. Certainly our patient had lived for 25 years. In Bruckner's series there is one patient who had had the syndrome for 28 years.

One might approach the solution of this case by seeing if any of the more commonly cited causes of the superior vena cava syndrome are appropriate. I think it inconceivable that a man having bronchogenic carcinoma which had spread to the mediastinum could live for 25 years. The extensive study five years prior to this admission failed to substantiate that diagnosis. The chest film is not compatible with this lesion and the bronchoscopic and sputum examinations were negative. Admittedly, carcinoma of the lung can exist for a considerable period of time without producing a density in the chest film, but hardly for 25 years. I think we may dismiss bronchogenic carcinoma from further consideration. Could this man have had a malignant lymphoma? Again, I think it unlikely that he could live with mediastinal involvement by lymphoma for 25 years. He was examined several months prior to his demise and was found to be free of lymphadenopathy and hepatosplenomegaly. In fact, he was described at that time as being somewhat obese and not at all cachectic. None of the constitutional symptoms of lymphoma was reported. X-ray evidence of mediastinal lymphoma and teratoma was lacking. I do not believe this man's problem was caused by an aortic aneurysm, either luetic or arteriosclerotic. He had a persistently negative serologic test for syphilis which reduces the probability of lues considerably. Furthermore, the chest x-ray film did not show aneurysmal dilatation of the ascending aorta. Patients with aneurysms in this location frequently have a systolic murmur audible at the cardiac base which is due to eddy currents set up by blood entering the dilated aorta. They also have a tambour-like aortic second sound. This patient had neither. He did not manifest any signs of aortic regurgitation which frequently accompanies aneurysmal dilatation of the ascending aorta.

For the solution of this problem we shall have to turn to the miscellaneous group of diseases known to cause superior vena cava obstruction. There is no evidence that the thyroid was diseased. I say this because lymphocytic thyroiditis is known to have caused this syndrome.[7] I believe this man had so-

called primary or idiopathic thrombosis of the superior vena cava. Of course, it is not idiopathetic at all, since it must be secondary to something, but all series of cases of superior vena cava syndrome include some due to thrombosis of the superior vena cava of undetermined causes. However, it is just as likely that this patient's superior vena cava syndrome was produced by chronic mediastinitis, in other words, by traction or compression of scar tissue within the mediastinum. I am making the latter my second choice only because the patient did not have a history of an antecedent illness such as pulmonary tuberculosis which could eventuate in chronic mediastinitis. Either diagnosis is consistent with the long duration of the patient's problem and the virtually normal chest x-ray films found on a number of occasions. Undoubtedly he also had arteriosclerotic heart disease. The immediate cause of death was, in my opinion, pneumonia of both lower lobes with toxemia.

Clinical Diagnoses

1. Superior vena cava syndrome, probably due to idiopathic thrombosis of the superior vena cava.
2. Bronchopneumonia, bilateral.
3. Coronary arteriosclerosis.

Dr. P. C. Dietz: The autopsy findings included several surprising features. Foremost among these was an acute purulent leptomeningitis involving the cerebral vertex and due to coagulase positive Staphylococcus aureus. Equally unanticipated was an acute superficial ulcerative endocarditis upon the free edge of the mitral valve which also yielded a Staphylococcus. Bronchopneumonia was found as expected and cultures of this process contained mixed flora. The heart weighed 500 gm. and its chambers were dilated. A healed myocardial infarct was located in the anterior basilar portion of the interventricular septum. The coronary arteries were severely atherosclerotic.

The right lung adhered firmly to the right lateral aspect of the mediastinum immediately superior to the right main bronchus. Here was a gritty, fibrous, anthracotic and focally minutely calcific tissue, undoubtedly replacing lymph nodes, in which a stenosed superior vena cava, the terminal portion of the similarly stenosed left innominate vein and the right vagus and right phrenic nerves

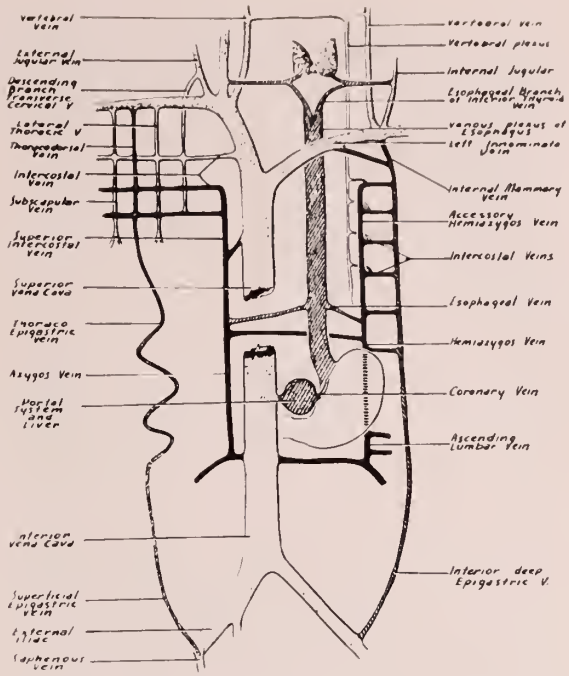

Fig. 2—Diagram of potential collateral circulation in superior vena cava obstruction. (Reproduced with permission from Klassen et al.[10])

Fig. 3—Roentgenogram obtained nine days prior to final hospital admission.

were incorporated. Against this lay the adherent thickened right pleura. The azygos vein entered the intact portion of the superior vena cava immediately below its stenosed segment. However, the azygos vein

was obviously compressed by the enlarged, congested and indurated right lung, the dilated right atrium of the hypertrophied heart and the dilated pulmonary artery. No aneurysm of the aorta was found. The thyroid weighed 35 gm. and was histologically involuted. There were occasional calcific foci 1 to 2 mm. in diameter subpleurally in both lungs. No other evidence of ancient lung disease was found and there were no other pleural adhesions. The thoracic tissues were markedly edematous. Sections of the mediastinal scar tissue revealed no granulomatous lesions, acid fast bacilli and fungal particles, and cultures produced only the metastatically derived Staphylococcus. No fresh venous thrombi were seen.

Thus, we are not able to hold a specific infectious agent responsible for the one-time right tracheobronchial lymphadenitis which at least 25 years before the patient's death was productive of right mediastinitis and which then resulted in constrictive stenosis of the superior vena cava. Hinshaw and Rutledge[8] rightly expressed their surprise that this sequence of events does not occur more often when they recalled the important drainage of the numerous lymph nodes which are in close relationship to the superior vena cava. The fact that this patient survived these many years is undoubtedly due to the gradual development of the constriction. It has been repeatedly emphasized that the severity of symptoms and signs of the superior vena cava syndrome depends not only upon the level and degree of obstruction of the vessel but also upon the rate at which that obstruction occurs and the ability of circulatory compensation to develop.[5, 9, 10]

In this patient blood from the head and neck descended along the external jugular veins, and blood from the arms along the cephalic veins, all entering into a dilated venous plexus on the anterior thoracic wall. This, in turn, anastomosed with perforating branches of the internal mammary veins and via these with intercostal veins which, finally, drained into the azygos system. A lesser amount of distention of anterior abdominal veins occurred. This was for him an efficient system. The left side of the head and neck and the left arm were drained over a route somewhat more circuitous than was the right side, and the venous pressure was greater on the left than on the right. One may imagine that so long as myocardial function was adequate, venous pressure in the dilated systems of the upper half of the body was not so great as to create edema. When cardiac decompensation occurred, edema of tissues resulted. When thereupon the azygos vein became compressed or incompetent, the superficial and deep abdominal vessels and vertebral plexus became of much greater importance. The return of blood from the head, neck, upper extremities and the thorax was then through the inferior vena cava. In such metabolically subnormal tissue due to venous stasis, infection would occur with greater than normal ease. Whether the initial focus of infection was in the lungs, throat or elsewhere we do not know. In any event, septicemia occurred rapidly with the ultimate development of meningitis.

Anatomical Diagnoses

1. Superior vena cava and left innominate vein stenosis due to ancient fibrous mediastinitis of unknown cause.
2. Acute purulent leptomeningitis (Staphylococcus aureus).
3. Acute bacterial endocarditis (Staphylococcus aureus).
4. Bronchopneumonia, bilateral.
5. Coronary atherosclerosis.
6. Healed myocardial infarct, ancient, anteroseptal.

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PRESIDENT'S PAGE

The Big Lie

PSYCHOLOGICAL warfare is not of recent origin. Its roots do not stem from Freud or Jung, or latter day disciples. The idea of deceiving someone by some devious means must have burned in the mind of man's forebears as he stalked through the jungle, making a loud noise to frighten enemy or animal. The idea of deceit was used by early people in their intermittent struggles, wherein the tribes made the most noise possible with horns blowing, bells ringing, cymbals clanging, and great shouts from the combatants. Thus, those who made the most noise and commotion were frequently the winners by convincing their adversary they must be hopelessly outnumbered.

Today, in a more enlightened age, we find the practitioners of deceit are not as crude but the method is the same. In war and peace they resort to what has become known as the "Big Lie." Hitler used it to good advantage; Stalin improved on the technique; and now, some politicians are showing them what smooth operators they are.

A statement that stretches the truth, that is repeatedly made by Mr. Abraham Ribicoff, Wilbur Cohen and fellow workers, is that the social security program is "insurance." Their position has been challenged repeatedly by many experts and knowledgeable people who should know what insurance is and what it is not. Those who question Mr. Ribicoff's loose use of the word include insurance experts, pedagogues, the law makers of the land, and finally the Supreme Court of the United States which has ruled that social security is a government welfare program, not insurance.

Another favorite statement by Mr. Ribicoff of H.E.W. is that the American Medical Association has the largest and most powerful political lobby in Washington. This ridiculous statement is trotted out on almost any occasion when he speaks in public or to the press, the latest assertion being made as this is written, at a fund-raising dinner in Milwaukee. Who pays for this star performer? Is this tab picked up through someone's largess, are taxpayers' dollars being used to subsidize his "special interest" campaign, or is it paid from the dimes and dollars contributed by hopeful people for an honest liberal political party, but who find themselves confused by the statements of some of its spokesmen? What a price to pay! The fact of the matter is that the A. M. A.'s "most powerful lobby in America" has but 15 people, including the clerical help, in its Washington office. There is no doubt in my mind but that the Volunteer Firemen of Punxsutawney, Pennsylvania, or the Dog Catchers Association of Ossiwissi, Iowa, could muster a larger force and still have enough left over for a baseball team. Perhaps, since Mr. Ribicoff is not succeeding very well with his pet bills—(King–Anderson) he would like to convey the impression of the A. M. A. lobby as the enormous ogre that blocks his path and not the fact that his program is erroneous. There is power in truth and that is why the opposition seems so powerful. There is growing evidence that his program is economically fallacious. It has been pointed out by some of our nation's law makers and other tax experts that with the progressive increase in the social security tax and raising of the maximum taxable income ceiling, the eventual total social security tax will exceed the present high income tax rate. Does this make sense? Come, Mr. Ribicoff, even Don Quixote did better! At least he tilted at windmills and did not bay at the moon!

Should not Mr. Ribicoff admit that the Kerr–Mills Act is the law of the land, rather than ignore it? Should he not congratulate the physicians and others everywhere who

are supporting its implementation in state after state all over America to enable every aged person who needs help to secure the health care he requires? Is it honest to fail to speak of this effort and thus imply there is no positive action to solve economic and social health problems?

Have our present day tribal leaders reverted to the tribal custom of attacking with fiery fury many segments of American life? Is the considered planning of statesmen to be replaced with rabble-rousing hate programs? What arrogance this man possesses! What manner of man is this Mr. Ribicoff who does not seem to recognize the truth?

It is not a specially guarded secret in "Foggy Bottom" Washington that in return for certain political aid in the November elections, the present incumbent of the White House is rumored to have assured Mr. Ribicoff the next appointment to the Supreme Court of the United States. What a travesty this would be, to entrust to a man the great responsibility to seek out the truth, to administer justice, who does not seem to know the meaning of the word! "Mores the pity!"

one of a series

Medical Stamps

PHILIPPE–PROSPER AUGOUARD (1852–1951)

French ecclesiastic who worked in French Africa. After serving as a soldier in the Franco-Prussian War, he went to Africa in 1877 and became a Catholic Vicar Apostolic in French Congo. He founded many missions. Engineer, physician, geographer. In 1912 the French Academy of Moral and Political Sciences bestowed on him a $3,000 prize for his long services in French Congo. Made an Archbishop in 1915. French Equatorial Africa honored him on a stamp in 1952 to celebrate the centenary of his birth. #C36

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Enterprise of the First Water

NEWS THAT the doctors of the River Falls Clinic have established two new scholarships at the Wisconsin State College at River Falls should bring a glow of pride to every medical man interested in the future of his profession. The scholarships are annual awards made to a freshman and a sophomore majoring in pre-medicine who have attained outstanding academic achievement and who show promise of excellence in the science of medicine.

In a single practice demonstration of their attitude of civic responsibility, the doctors of the River Falls Clinic have produced a large treasury of good will for themselves and for members of their profession in their community. They have also made a major contribution to a continuing recruitment of qualified medical students for our schools.

The members of the River Falls Clinic are Drs. Ferdinand O. Grassl, P. H. Gutzler, Roland M. Hammer, and Paul S. Haskins. As a group they have earned the gratitude of the State Medical Society for a fine act that has done honor to us all. Let us applaud them by emulating their shining example—D. N. G.

GUEST EDITORIAL

Help Wanted

FOR ABOUT ten years there has been a gradual decrease in number and quality of medical school applicants. With undergraduate schools literally bursting at the seams, and parents worrying about college admission for little Johnny at age three, this lessening of interest in medicine is really quite remarkable. Although the situation is not yet critical, the trend is noticeable enough to concern us all.

The deans of our two medical schools have been most active in the programs carried out by the State Medical Society's Commission on Hospital Relations and Medical Education. However, they should probably be allowed to devote their time to maintaining standards and instituting imaginative changes in curricula. Recruitment of candidates, on the other hand, should be the responsibility of each of us.

One of the most disappointing aspects of our work has

been the lack of enthusiasm of many doctors themselves toward encouraging young people into our profession. We in the Commission feel that medicine has a certain basic value that transcends these temporary swings in public opinion. It all begins and ends with these young students, and a word of encouragement from a personal physician means more than anything a commission can possibly do.

We ask your help in this endeavor.—T. H. McDonell, M.D., *Member, Commission on Hospital Relations and Medical Education, and Chaiman of its Committee on Medical Student Recruitment.*

GUEST EDITORIAL

Remember the Oath

"I DO SOLEMNLY swear by that which I hold most sacred: That I will be loyal to the profession of medicine, and just and generous to its members, . . . These things I do promise and in proportion as I am faithful to this my oath may happiness and good repute be ever mine—the opposite if I shall be forsworn."

The above, not quite the original words of Hippocrates, may be regarded by some as outdated, old fashioned, and irrelevant, but is it? I think not. I believe these words have meaning and purpose for us today.

The preceding editorial clearly states the problem: a steady decrease in the number and quality of medical school applicants. Fewer applicants means fewer doctors—badly needed doctors.

It *is* our responsibility and duty to help encourage and guide capable young people into medicine. If we do not—what hope, what chance has medicine in the future?

Read over the old "Oath" and then decide what you will do.—Robert S. Gearhart, M.D., *Chairman, Commission on Hospital Relations and Medical Education.*

For the Wealthy Only?

THE GLOOMY fact of the growing shortage of practicing physicians was brought into sharp focus by the recent report of the Commission on Hospital Relations and Medical Education of the State Medical Society. A very serious dearth of medical personnel is no longer something to be worried about as a prospect. We are already faced with it here in Wisconsin.

The startling figures produced by the Commission bear repeating:

1. While the United States physicians-per-capita-population figure is 125 per 100,000 population, Wisconsin has only 104 doctors per 100,000 population.
2. Wisconsin ranks 44th in the nation in terms of the ratio of applicants for medical school to population.
3. In order to bring the ratio of physicians to population to the national average and to maintain it there, there will have to be about 240 new physicians practicing in Wisconsin each year for the next 15 or 20 years. At the present time, only about 135 new doctors begin practice in Wisconsin annually.

That a crisis exists is quite evident. Some professions might resolve comparable crises simply by reducing the standard of qualification for applicants. Medicine cannot afford this method. We must obtain competent people, and in order to do this, we must attack the impediments to those who are qualified but who may select other fields for one reason or another.

The Commission has already undertaken a program designed to promote interest in a medical career as well as to offer guidance counselling. It is hoped that every county medical society as well as every individual doctor will support this program by helping to bring young people into the field of medicine who belong in it.

But an extremely significant clue to the problem is the fact developed by the Commission that only 14% of medical student graduates come from families earning $5,000 or less annually—the national average. About 43% come from families with an annual income of over $10,000. Even so, over 99% of all medical students work some or all of the time while in medical school. As the Commission reports, "Deans recommend no more than 10 hours of outside work per week, yet 10% of medical students work 40 hours per week or more, the average student works 15 hours weekly."

With a medical education costing an average of $11,642 for four years, the medical student must either be exceptionally deter-

mined or the scion of a well-fixed family. The Commission goes on to report that while the Charitable, Educational and Scientific Foundation of the State Medical Society already has nearly $80,000 out on loan at the present time, many applications for loans are still pending for lack of funds.

As the Commission suggests, the quickest and soundest way to increase recruitment of qualified medical personnel is to broaden the economic base from which applicants are drawn. To do this, we must make money available to young people who appear to have the potential of good doctors, so that they can devote themselves full time to their education. The best way to do this—in fact, the only way in which doctors can be sure that aid is given only to serious students who have proper qualifications—is through organizations such as our Charitable, Educational and Scientific Foundation. By increasing our contributions to the Foundation we can make more funds available to men and women who have the ambition and capability of becoming good doctors. In our own way, we can do much to be sure that Wisconsin has enough doctors for its need.—D. N. G.

GUEST EDITORIAL

Relentless Eye

A TELEVISION camera can be a pretty menacing gadget when you're in front of it for the first time . . . or even if you've done it more than once. The key to equanimity, of course, is preparedness. And part and parcel of preparedness is a positive understanding of the power of the medium. What you say can be a real help to medicine in your community . . . if you say the right things.

The times behoove us to make the most of every reasonable opportunity we can get to speak up for medicine and the practicing physician—what he is, what he does and what he's trying his level best to do. Talk is positive; it not only indicates a desire to tell your side of the story but also implies a willingness to listen to the other guy. Silence breeds suspicion, and helps rumors, half-truths, and downright lies to solidify in the magma of people's minds.

Health people find themselves at the barricades now, without quite knowing why. Could be it's because they have never had the time or felt the need to tell their story—they just assumed they were needed, even loved, and that their deeds spoke for them.

We have found it isn't necessarily so, and that a passive approach to justification of ourselves is highly dangerous. In our new era of "popular sovereignty" regarding matters medical, we just have to take an active hand in promoting the best in our work, revising the rest, and making ourselves into medical statesmen in the process. We really have no other choice . . . and we must begin now.

Now, to this business of statesmanship. A *sine qua non* thereof is effective communication, and television is one of the best media available to achieve real body-and-soul communication with a mass audience. So, when the opportunity presents itself, don't fear the "eye;" rather, as a noted TV entertainer says, welcome it.

But, be prepared. And this brings me to an important point. Your state medical society and other medical organizations have an experienced public relations staff that stands ready, willing, and eager to counsel doctors who are in the shadow of the video camera. Recently we were subjected to the considerable discomfort of viewing a general practitioner being interviewed on a widely-known network show. This good man steadfastly refused to acknowledge and promote the concept of family practice, even under constant prodding by the interviewer. Had he not missed the repeated cues, millions of Americans would be better informed today as to the continued existence, the strength and the availability of the family doctor–general practitioner. We cannot buy opportunities such as this; we must be alert to them when they present themselves.

Help us to help you. Pass the word through your medical organizations. Encourage your colleagues to use the medium. All of us have an obligation to promote medicine as a force for good in America.—MAC F. CAHAL, J. D., *Executive Director, American Academy of General Practice.*

The Great Give-Away

WHETHER a chiropodist should be called a chiropodist or a podiatrist is for the most part a matter between the chiropodist and the person whose feet he is treating. The

statutes of the State of Wisconsin can define one or the other without world-shaking significance, except to chiropodists, who, understandably, would not wish to be confused with chiropractors. But when legislative fiat undertakes to confer academic degrees in the field of medical science, the entire bona-fide medical profession should become alarmed.

The recent request of the Wisconsin State Podiatry Society for legislation to permit chiropodists unrestricted use of the title "Doctor" is alarming in itself. But more importantly, it points to a growing tendency on the part of some paramedical practitioners to clothe themselves (at no educational effort) with the dignity and prestige of the qualifications of a physician or surgeon. To the uninformed patient, a podiatrist, for example, is a "foot doctor," as the name etymologically suggests. A "foot doctor" is a "foot specialist." Therefore, by an extension of this logic, why consult a "regular" doctor when something goes wrong with the feet?

The encroachment of chiropodists, chiropractors, optometrists and others on medical practice was started with licensure; it is encouraged by legislative bestowal of academic degrees; and if it isn't stopped, it will end with medical technicians parading as medical doctors in practice as well as in style.

It takes most physicians at least ten long years of hard work to earn their title, but chiropodists—again as a current example—would acquire it by legislative definition, designating chiropodists as "physicians" for the purpose of using narcotics in the treatment of podal ailments. Thus, the chiropodist who is defined in "Hospital Accreditation References," a publication of the Joint Commission on Accreditation of Hospitals, as ". . . in the nature of a technician, functioning under the surveillance and supervision of a physician" is prepared to take the place of the physician. And he doesn't have to spend ten years doing it.

Every time you refer a patient for treatment to a chiropodist, clinical psychologist, optometrist or any other practitioner of a paramedical service, you may be encouraging him to greater authority than his license or training warrants. Because you are a medical doctor, your referral helps to establish the prestige of the paramedical practitioner in the eyes of your patient. Your patient thereupon may shortcut you and consult the paramedical practitioner directly for services.

Paramedical personnel exists only as an area of technical assistance working closely with and often under the direction of a licensed physician and surgeon, the only practitioner whose license is unrestricted.

The medical profession fails in its obligations to the health of the people if it permits it any other way.

Do not cooperate with those limited licensees who practice beyond their qualifications and their license. You owe this to your patient. You owe nothing to limited licensees as such.

And finally, be sure to let your State Representative and Senator know how you feel about the danger to the community resulting from the attempt of paramedical groups to acquire legislatively what is denied to them academically.—D. N. G.

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THE MEDICAL FORUM

Public Health Fares Well In 1961 Legislature; Kerr–Mills Action Held Over For Fall Agenda

Introduce 200 Bills On Health Subjects

Some 200 bills and substitute amendments with health implications were introduced in the recently concluded session of the Wisconsin Legislature, one of the longest in the history of the state.

The lawmakers will return to Madison on October 31 to complete action on tax and certain other matters.

Of the 200 measures under constant observation by the Commission on Public Policy of the State Medical Society, 181 related to a broad variety of matters of health and the practice of medicine; the remainder were of direct or indirect interest to voluntary health insurance plans such as WPS.

Although the legislature has been criticized in some corners for lack of activity—such is not the case for medicine. From the start of the session the Commission on Public Policy, assisted by physicians from all parts of the state, hospital administrators, clinic managers, and other friends of medicine, made numerous appearances before legislative committees to offer information and opinions on bills.

Here are some of the major results:

PERSONAL SERVICE

Of major importance among those bills already signed into law is 587, A. authorizing the formation of Personal Service Corporations in Wisconsin. This will allow professional persons, licensed, certified, or registered under state law, to incorporate for the purpose of deferring taxation on retirement funds until benefit is received.

CHIROPRACTIC

In their perennial appearance, the chiropractors this session caused to be introduced companion bills (340, A. and 249, S.) which would allow an employee to demand that his employer provide chiropractic treatment under Workmen's Compensation.

The Senate bill was indefinitely postponed and the Assembly bill passed in that house but was defeated in the Senate.

PODIATRY

The podiatrists (chiropodists) had three major bills in this session.

One which originally would have defined the chiropodist as a "physician" so that he could use narcotics (345, A.) passed the Assembly but was killed in the Senate. It was opposed by the Society on the basis that there is not sufficient knowledge of the chiropodists' education

(Continued on page 502)

Newly Passed Law Will Require Radiation Sources Registration

On September 14, the Industrial Commission began to set up machinery for the implementation of Bill 623, S. requiring the registration of radiation sources in Wisconsin.

According to the new law, radiation installations in the state shall be registered by January 1, 1962. There is no indication at this time as to when the registration will start.

The Commission is presently studying forms used in other states which already have such a law, and a schedule for registration will be set up some time in the future.

In carrying out the instructions of the new law, passed in the recent legislative session and signed by the Governor, the Commission will call on an Advisory Committee on Radiation which was formed about a year ago.

Exempt from the registration, according to the law, are sources licensed by the Atomic Energy Commission. Also, the Industrial Commission may exempt any source or installation which the Commission finds does not constitute undue radiation hazard.

A registration fee of not less than $1 or more than $5, to be determined by the Commission, will be charged to each operator registering under the new law. Any person who fails to register a radiation installation covered by the law may be fined not more than $500 or imprisoned not more than six months, or both.

The Industrial Commission is to consult with the State Board of Health in establishing and maintaining the system of registration, and both will report independently to the 1963 Legislature summarizing the results and making recommendations regarding future steps to be taken in the area of further regulation.

Public Health Fares Well In 1961 Legislature

(Continued from page 501)

and training. At Society request the AMA will undertake a study of chiropody in the next year.

A second, (490, A.) redefining the practice of podiatry was also opposed by the Society. After lengthy debate it was substantially amended and ultimately passed by both houses. If signed by the Governor, it will define podiatry as "the diagnosis or mechanical, medical or surgical treatment, or treatment by the use of drugs, of the feet, but does not include major surgery or the use of a general anesthetic. Diagnosis or treatment shall include no portion of the body above the feet except that the diagnosis and mechanical treatment shall include the tendons and muscles of the lower leg insofar as they shall be involved in the conditions of the feet."

A third bill, (346, A.) bringing podiatry under the state public assistance laws was supported by the Society, passed both houses and awaits the Governor's action.

OPTOMETRY

Bill 188, A., as originally introduced, would have expanded the rule-making powers of the Board of Examiners in Optometry, possibly permitting changes in the definition of optometry without legislative action. When amended to omit this expansion, but still allow changes in the section of the Optometry Act relating to "unprofessional" conduct, SMS supported the bill. It was passed and signed by the Governor.

LOCAL PUBLIC HEALTH ORGANIZATION

The Society supported one bill which would have eliminated all township health officer positions and created a county health commission, and another which would have revised the cost sharing of county and city-county health departments by the governmental levels concerned. The first (2, S.) was passed after substantial amendment but the action was made permissive rather than mandatory and the second died in the Senate. Two other bills (335, A. and 295, S.), creating an advisory committee on local health services to the State Board of Health, were both indefinitely postponed.

PUBLIC EDUCATION NEED CONTINUES

Legislative action on the two current concepts of providing financial assistance for medical care costs of the aging has reached a temporary lull. The legislature has adjourned with Kerr–Mills implementation on the agenda for a fall session, and action on the King–Anderson bills in the Congress does not seem likely this year.

However, the need to explain to the general public the differences between these two approaches and the views of medicine on the two concepts remains one of the major tasks facing the profession.

The following aids are available from the State Medical Society, Box 1109, Madison, Wis., for use in local programs:

1. **Motion Picture**
   Dr. Edward R. Annis, Miami, Florida, interviewed by Jerry Deane, news director of station WISC–TV, Madison, on the subject of financing health care for the aged. Suitable for showing to medical or non-medical audiences. 16 mm film, black and white, 15 minutes.
2. **Tape Recording for Medical Meetings**
   A speech by Dr. Edward R. Annis before the annual County Medical Societies Presidents' and Secretaries' Conference, March 22, 1961, on the subject of health care for the aged. This recording is for physician audiences only. 28 minutes.
3. **Tape Recording for General Public**
   An interview with Dr. Edward R. Annis and Dr. H. Kent Tenney, Madison, on the subject of health care for the aged. Suitable for playing before medical and non-medical audiences. 28 minutes.
4. **Speakers Kit**
   Background materials and sample speeches on Health Care for the Aged for use at local gatherings.

TRAFFIC SAFETY

A bill (414, A.) requiring installation of front seat belts in all new automobiles sold in Wisconsin starting in 1962 has been passed by both houses and awaits the Governor's signature.

Another bill (76, A.) would have stated that the licensed operator of a motor vehicle gives "implied consent" to chemical test for intoxication, and refusal to do so would have brought suspension of his license. It was indefinitely postponed.

AGING

Bill 267, A., establishing a State Commission on Aging, was passed by both houses and awaits the Governor's action.

SCHOOL HEALTH

Awaiting the Governor's action after passing both houses is a bill (197, S.) which requires physical examinations for college teachers and other personnel in institutions of higher learning, the same as are now required for employees in elementary and secondary schools.

MEDICAL EDUCATION

A bill (695, S.) to provide a simplified method for an individual to make his body available for educational purposes passed both houses and has been signed into law. Previously, the individual could informally express this desire, but the implementation of it rested solely with his next-of-kin.

Dr. Otto A. Mortensen, associate dean of the University of Wisconsin Medical School, in asking the Governor to sign the bill, stated: "I wish to make it very clear that both medical schools have and will fully respect the feelings of rela-

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Public Health In Legislature

(Continued from page 502)

tives and would not accept a body against the wishes of any responsible person."

He stated that the UW Medical School had not experienced difficulty in obtaining material for study of human anatomy, but that Marquette University School of Medicine has been critically handicapped in this area.

REGISTRATION REQUIREMENTS

Passed by both houses and signed into law was a bill (623, S.) which directs the Industrial Commission to register all radiation-producing devices in the state. The State Medical Society supported the principle of the bill, but preferred that registration be accomplished under the State Board of Health. See page 501 for details.

HOME NURSING

A bill to authorize public health nurses to render home nursing care on a fee basis (131, S.) has passed both houses but has not been acted upon by the Governor.

The bill was opposed by the State Medical Society in the belief that this is a service which should preferably be performed on a voluntary basis rather than by government.

KERR–MILLS IMPLEMENTATION

High on the list of "unfinished business" for both houses when they return this fall are bills concerning the implementation of the Kerr–Mills Act in Wisconsin.

Held over were three bills. Twin bills, 550, A. and 466, S., which were drafted with the assistance of the State Medical Society, are currently in the Joint Finance Committee. Bill 630, A. was introduced later and with the Governors' backing. It was also held over for the fall session.

A significant development in the state was a recent statement by the Wisconsin Hospital Association in support of Bills 550, A. and 466, S.

Governor Nelson Approves Bill Changing Medical Practice Act

Governor Gaylord Nelson has signed into law a bill making revisions in the Medical Practice Act.

The bill (696, S.) introduced at the request of the State Board of Medical Examiners, was passed by both the Senate and Assembly in the recently concluded legislative session. It makes the following changes:

1. Corrects the immigrant application requirements by providing that the applicant for medical licensure need not be a citizen, but need only have filed a declaration to become a citizen.
2. Removes the July 1, 1961, expiration date on foreign medical school graduates and permits waiver of written examination by reciprocity or acceptance of marks in an examination conducted by the Educational Council for Foreign Medical Graduates.
3. Allows an honorably discharged member of the armed forces or federal public health service to obtain a temporary license to practice in an area where the Board finds an emergency need for medical personnel exists.
4. Updates the physical therapy registration section.
5. **Creates a new subsection which allows the Board to suspend a license or certificate of registration temporarily, and place its holder on probation for a period not to exceed three months, in lieu of starting a revocation action. The subsection contains three safeguards for the individual physician:**
   a. The Board must have knowledge or good cause to believe that the physician has been guilty of "improper or unprofessional conduct."
   b. No physician may have his license or certificate of registration suspended, and himself placed on probation, for more than two consecutive three-month periods.
   c. All Board actions under this new subsection are reviewable under Chapter 227 of the statutes.

In recommending to Governor Nelson that he sign the bill, the Society expressed the opinion that all of the revisions are in the public health interest of the people of the state.

SEARS FOUNDATION RECEIVES REQUEST

Norwalk, Wisconsin, has applied to the Sears–Roebuck Foundation for a community survey to determine if there is sufficient potential to attract a physician to the community.

HAVE YOU LOOKED AT YOUR INCOME PROTECTION LATELY?

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Health Bills In 1961 Legislative Session

BILLS PASSED AND SIGNED BY GOVERNOR

45, A.—Eliminates fees for reporting vital statistics.
111, A.—Budget Bill (Supported by SMS as it affected the University of Wisconsin Medical School).
188, A.—Optometry Bill, concerning the rulemaking power of the Board of Examiners in Optometry. (Originally opposed by SMS on the basis that it permitted the board to expand the practice of optometry, but supported by SMS when amended to remove this provision).
216, A.—Group health insurance available to municipalities.
233, A.—Permits the State Board of Examiners in Optometry to accept in whole or in part the certificate of the national board of optometry in lieu of its own examination. (SMS offered no objection).
346, A.—Adding chiropodists to definition of medical care under public assistance. (SMS supported).
500, A.—Exemption from narcotics act, to conform with federal law. (SMS opposed).
587, A.—Personal Service Corporation Bill—to allow certain professional people to incorporate for purposes of deferring federal taxes on retirement programs. (SMS sponsored).
87, S.—Notification of the coroner of death when there was no physician in attendance within 30 days.
197, S.—Requires physical examinations for college teachers and other personnel. (SMS supported).
201, S.—Licensing of Foreign Graduates.
323, S.—Discharge of mentally deficient persons from temporary to permanent discharge.
371, S.—Modernization of the Dental Practice Act. (SMS supported).
378, S.—Research on mental deficiency. Allows the Department of Public Welfare to enter the areas of mental deficiency and mental infirmity research.
426, S.—Allows direct admission from mental health clinics to the Wisconsin Diagnostic Center.
431, S.—Workmen's Compensation medical reports and ionized radiation.
507, S.—Release of information on certain patients in mental institutions so they can qualify for pensions, etc.
508, S.—Exempts public institutions and certain state and county officers from release of privileged information. (First amendment to Chapter 301 of 1959 session).
512, S.—Hospital liens for services on injured persons. (SMS supported).
581, S.—Research at Wisconsin Psychiatric Institute.
582, S.—Outpatient clinic services at Public Welfare institutions.
595, S.—Determination of disability in relief by physicians or a panel of physicians.
623, S.—Registration of radiation producing devices. (SMS supported in principle).
695, S.—Provide more effective mechanism for an individual to make his body available for educational purposes. (SMS supported).
696, S.—Changes in Medical Practice Act requested by Board of Medical Examiners. (SMS supported).

BILLS PASSED BOTH HOUSES BUT NOT YET SIGNED BY GOVERNOR

172, A.—Rehabilitation facility to be established as part of county jails.
236, A.—Release from custody of person "under the influence" while driving.
254, A.—Regulation of charitable solicitations. (SMS opposed).
267, A.—Establishment of a State Commission on Aging. (SMS supported).
272, A.—Changing definition of totally and permanently disabled persons.
414, A.—Requires installation of front seat belts in all new automobiles sold in Wisconsin starting in 1962. (SMS supported).
490, A.—Changes in chiropody chapter. (SMS opposed).
2, S.—Authorized replacement of town health officers with county health commission. (SMS supported).
131, S.—Authorizes home nursing care by public health nurses on a fee basis. (SMS opposed).
530, S.—Temporary educational certificates for foreign nurses.
585, S.—Investment board purchase of Public Welfare student loans.
682, S.—County–city county and multiple health departments.

BILLS HELD OVER UNTIL FALL SESSION

550, A.—Health Assistance Act for Aging—implementation of the federal Kerr–Mills Act. (SMS sponsored).
600, A.—Registration of radiation sources and establishment of nuclear development office. (SMS supported in principle).
630, A.—Medical aid for the aging. (SMS preferred Bill 550, A. above).
465, S.—Relating to Wisconsin Neurological Foundation.
466, S.—Health Assistance Act for the Aged. (SMS sponsored.)
743, S.—Definition of dangerous drug.

(Continued on page 505)

BILLS RETURNED TO AUTHOR

155, A.—Prohibits charging fee for adoption by agencies.
253, A.—Silicosis in Workmen's Compensation.
273, S.—Nursing home licensing into three categories. (SMS opposed).
404, S.—Board of Nursing authority to enter and inspect premises. (SMS opposed).
659, S.—Mandatory licensing of practical nurses, nurses aids and hospital attendants in counties having population of 500,000 or more.

BILLS DEFEATED

170, A.—Establishing a Governor's Commission on Alcoholism. (SMS supported).
340, A.—Bill to place chiropractors under Workmen's Compensation (SMS opposed).
345, A.—Add chiropody to narcotics chapter. (SMS opposed).
536, A.—Aid for dietary materials for phenylketonuria. (SMS supported).

BILLS INDEFINITELY POSTPONED

1, A.—Sale and use of economic poisons.
76, A.—Consent to chemical test for intoxication when driving.
198, A.—Out-of-state scholarships for Wisconsin residents.
335, A.—Advisory Committee on Local Health Services. (SMS supported, but objected to certain wording in the bill.)
344, A.—Adding hospital drug room to the pharmacy registration law. (SMS opposed).
499, A.—Requiring first aid training for ambulance attendants.
3, S.—Financing county Department of Health. (SMS supported).
202, S.—Creating a State Commission on Aging. (SMS supported).
249, S.—Chiropractic under Workmen's Compensation. (SMS opposed).
272, S.—Financial reporting by hospitals, nursing homes, etc. (SMS opposed).
294, S.—Implied consent to blood test of auto operators.
295, S.—Advisory committee on local health services. (SMS supported, but objected to certain wording).
362, S.—Licensing of nursing homes. (SMS opposed).
390, S.—Expansion of definition of podiatry. (SMS opposed).
391, S.—Use of narcotics by chiropodists. (SMS opposed).
407, S.—Requiring hospitals and nursing homes to file financial reports. (SMS opposed).
410, S.—Scholarships for nursing educators.
435, S.—Governor's Commission on Alcoholism. (SMS supported).
478, S.—Conversion provisions in non-profit health insurance plans.
531, S.—Licensing of nursing homes as "skilled" and "minimum".
571, S.—Physicians certify rather than make affidavit on reports under Mental Health Act.

Doctor Lindert Appointed To Editorial Board

Dr. M. C. F. Lindert, Milwaukee, has been appointed to the Editorial Board of the *Wisconsin Medical Journal*, the official publication of the State Medical Society.

Doctor Lindert, a specialist in internal medicine, recently completed a five-year term on the Society's Commission on Scientific Work. As chairman of this Commission last year he had responsibility for the postgraduate medical programs sponsored by the State Society.

Doctor Lindert is a graduate of the University of Minnesota Medical School and now serves as associate clinical professor of medicine at Marquette University School of Medicine.

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S.M.S. To Co-Sponsor Contest On Employment Of Handicapped

The State Medical Society will again co-sponsor the annual statewide essay contest conducted by the Governor's Committee on Employment of the Physically Handicapped.

The contest, which runs from October 1, 1961, to February 1, 1962, is open to all Wisconsin high school juniors and seniors. Topic this year is "The Role of the Community in the Employment of the Handicapped."

Last year almost 700 essays were judged by the Governor's Committee with an estimated 6,500 students participating.

The Society urged local physicians to work closely with district managers of the Wisconsin State Employment Service in promoting the event at the comunity level.

A NEW ADDITION to the grounds of the State Medical Society is the locomotive bell, pictured above, presented by Dr. Gunnar Gundersen of La Crosse. The bell has been mounted on the east side of the building adjacent to the fireplace donated by the Grant County Medical Society.

Add Fluoridation

The State Board of Health has reported approval of installation of fluoridation equipment at Benton and Jefferson.

Over 2000 Benefit From Speakers Service

Some 2,254 physicians attended meetings during the past year to hear speakers furnished by the Speakers' Service of the State Medical Society.

In all, the service provided speakers for 79 meetings between July 1, 1960, and June 30, 1961. Requests for speakers came from 27 county medical societies and three councilor districts.

Financial support for the service came from the Charitable, Educational and Scientific Foundation of the State Medical Society, Merck, Sharp & Dohme, American Cancer Society, Wisconsin Heart Association, Wisconsin Anti-Tuberculosis Association, and the State Board of Health.

Launch Campaign for Better Mental Health

Opening step in a concerted campaign against mental illness and for better mental health for all will be taken in a preliminary planning conference to be held September 29–October 1 by the American Medical Association.

Poison Control Centers Topic Of Conference On October 12

A conference on the "Administrative Aspects of Poison Control Centers" will be held Thursday, October 12, at the Wisconsin Center on the University of Wisconsin campus in Madison.

It is sponsored by the State Board of Health, University of Wisconsin Extension Services in Pharmacy, Wisconsin Hospital Association, Wisconsin Pharmaceutical Association, Wisconsin Society of Hospital Pharmacists, Wisconsin Nurses Association, Wisconsin Safety Council, and State Medical Society.

Dr. James L. **Wardlaw, Jr.**, director of the Bureau of Maternal and Child Health and medical advisor of the Poison Control Committee of the State Board of Health, will open the program at 11:50 a.m. speaking on "Guidelines for Poison Control Centers."

The afternoon session will include reports, discussion and formulation of a suggested administrative guide. Describing the roles of various professions will be: Hospital Administrators—Charles **Welch**, Edgerton; Physicians—Dr. Franklin J. **Mellencamp**, Milwaukee; Nurses—Mrs. Priscilla J. **Rice**, R.N., Green Bay; Pharmacist—Robert J. **Kubiak**, Oshkosh; Community Health Agency—John A. **Bacharach**, Eau Claire; Other Community Agencies—Sgt. C. R. **Marthaler**, Beaver Dam.

Henry J. **Verhulst**, director of the National Clearinghouse for Poison Control Centers, Washington, D. C., will talk on "Where and How to Find the Answers."

Speaker at an evening smorgasbord at the Madison Inn will be Dr. Edward Press, Public Health Director, City Health Department, Evanston, Illinois. His topic is "Telling the Prevention Story."

A DONATION OF BOOKS to the University of Wisconsin Medical School library comes from the library of the late Dr. Arthur Wiesender, Berlin, Wis. Examining one of the more than 1,000 volumes is Miss Helen Crawford, librarian, of the medical school. The books, donated to the Charitable, Educational and Scientific Foundation of the State Medical Society by Mrs. Wiesender, will be used in the library, sent to other libraries around the country, and given to medical students.

Doctor Heidner Heads AMEF For Wisconsin

Dr. A. H. Heidner, West Bend, has been re-appointed chairman of the American Medical Education Foundation program in Wisconsin.

As chairman of the AMEF campaign in the state, he is charged with raising funds to support the nation's medical schools.

Last year Wisconsin physicians contributed more than $16,000 to the AMEF which was distributed to various medical schools for their use in providing more adequate laboratories, teaching facilities and personnel.

DR. A. H. HEIDNER

Doctor Heidner has served as president of the State Medical Society, president of the Wisconsin Commission for the Improvement of Patient Care and has held many other offices in his state and county societies.

Dr. Gundersen Heads Medical Political Unit

Dr. Gunnar Gundersen, La Crosse, has been named chairman of the American Medical Political Action Committee.

Doctor Gundersen stated the impetus for organizing AMPAC came from the American Medical Association, but the new organization "will function independently and will occupy its own quarters in Chicago."

DR. GUNNAR GUNDERSEN

Its activities will be financed in part by the AMA and in part from AMPAC members. Membership will be open to all physicians licensed to practice in the United States, their spouses, and adult members of their families.

Primary mission of AMPAC, according to Doctor Gundersen, "will be to guide such activities as organization of state and local political committees; to provide such committees with information; to prepare and distribute records of political parties and candidates; and to assist with voter registration drives and get-out-the-vote campaigns.

He added that the AMPAC funds contributed by the AMA will not be used for financial support of political candidates or for similar activities prohibited by federal or state statutes.

AMPAC will be bipartisan, voluntary and non-profit, Doctor Gundersen added. Its purpose is to organize the medical profession to participate in year-around political activity on all levels of government.

S.M.S. Placement Service Aids Community Seeking Physicians

The community of Chetek, in northwestern Wisconsin, now has two more physicians to aid 80-year-old Dr. R. W. Adams in caring for the medical needs of the area.

Playing an important part in the sequence of events which brought Dr. Joseph E. *Powell* and Dr. Mac C. *Roller* to the community was the State Medical Society's Placement Service.

Earlier this year, Chetek contacted the Society for aid in locating a physician. Data on the city was then included in the periodic listing of communities seeking physicians which is circulated to physicians seeking locations in the state.

The service accomplished its mission when Doctor Powell requested a copy of the listings. He and Dr. Roller, long-time friends and graduates of Indiana University Medical School, were completing their internships in Denver, Colorado, and were seeking a location in the state.

Meanwhile, Chetek had contacted the Sears–Roebuck Foundation to obtain aid in making the community attractive to physicians. A survey by the Foundation, which operates its program in cooperation with the American Medical Association, indicated the town could support additional physicians.

A general meeting resulted in the decision to build a new $50,000 clinic and the Foundation responded with advice for the fund raising drive and plans of a model clinic.

On July 30 the residents of Chetek turned out in force to dedicate the building and welcome their new physicians. Lt. Gov. Warren Knowles and Dr. Gunnar Gundersen of La Crosse, former president of the AMA, were the principal speakers.

Said Lt. Governor Knowles, "Nowadays all too many people seem to feel that federal aid is the only answer to local problems. But America was built by men who solved their own problems with hard work and determination."

The spirit of the community, cited by Doctors Roller and Powell as the reason they chose Chetek, was evident when the town's effort to obtain additional medical service was featured on a nationwide television program August 27.

State Medical Society Appointments Listed

A number of appointments to commissions and committees have been announced by the State Medical Society.

Dr. Richard B. **Windsor**, Sheboygan, has been named chairman of the Division on Safe Transportation of the Commission on State Departments.

The Division is concerned with the medical aspects of highway safety and works closely with governmental units and voluntary agencies with similar interests in Wisconsin. Doctor Windsor has been a member of the Division since 1959.

New chairman of the Committee on Disaster Medical Care is Dr. J. S. **Wier**, Fond du Lac. The Committee works with and advises groups in organization and training in the medical aspects of civil defense. Doctor Wier has been a member for the past 11 years.

Three new members of the Commission on Medical Care Plans are Dr. J. H. **Houghton**, Wisconsin Dells; Dr. E. P. **Ludwig**, Wausau; and Dr. Howard **Mauthe**, Fond du Lac.

The Commission directs the activities of the Society's health insurance program, Wisconsin Physicians Service. Other duties include cooperation with private health insurance carriers; aid to the Federal government in administration of such activities as Medicare and the Federal Employees Insurance Program; and advice to state governmental units on such matters as implementing the Kerr–Mills Act in Wisconsin.

Representing the Third Congressional District on the Committee on Health Economics of American Life (HEAL) will be Dr. R. A. **Pribek**, La Crosse.

The Committee keeps society members informed on Federal legislative matters concerning health and the practice of medicine and offers information and testimony on congressional matters of particular importance to Wisconsin.

Dr. Harold E. **Oppert**, Viroqua, and Dr. J. F. **McIntosh**, Madison, are new members of the Commission on Public Policy. The Commission guides legislative matters for the Society, developing legislation to improve health services and facilities for Wisconsin and supporting such bills in hearings before the legislature.

A new member of the Commission on Public Relations and Communications is Dr. C. A. **Olson**, Baldwin. The Commission directs the Society programs in public relations, health education, industrial health and rural health.

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WASHINGTON, D. C.

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Secretary of the Interior

Director, National Park Service

SECOND FORT CRAWFORD, the site of the Museum of Medical Progress, in Prairie du Chien, has been designated a Registered National Historic Landmark by the National Park Service of the Department of the Interior. Pictured above is a certificate presented by the National Park Service, and a plaque will be placed at the museum noting the recognition.

Fox Lake Participates In Sears–Roebuck Plan

Fox Lake citizens on July 13 voted to participate in the program of the Sears-Roebuck Foundation to locate a physician for the community.

The proposal includes construction of a community medical center, at an estimated cost of $40,000. Fund raising and construction would be up to the community which would then lease or sell the structure to the new physician.

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TRANSACTIONS OF 1961 REGULAR SESSION HOUSE OF DELEGATES

State Medical Society of Wisconsin

MAY 1, 2 and 3, 1961

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FIRST SESSION

Monday, May 1, 1961

The first session of the House of Delegates of the State Medical Society of Wisconsin, held on May 1–3, 1961, at the Hotel Schroeder, Milwaukee, Wisconsin, convened at 7:45 p.m., Dr. E. J. Nordby, Speaker of the House of Delegates, presiding.

REPORT OF COMMITTEE ON CREDENTIALS

The Committee on Credentials composed of Drs. N. A. McGreane, Darlington, Chairman; G. A. Behnke, Kaukauna; and P. E. Oberbreckling, Milwaukee, reported that it had verified the registration of 85 delegates and 6 alternate delegates entitled to vote at this first session of the House of Delegates. The Committee had been informed that Dr. Ralph T. Rank, Milwaukee, would act as delegate for the Section on Ophthalmology and Otolaryngology inasmuch as the regular delegate and alternate delegate were unable to attend. Also, the Committee had been informed that Dr. James V. Bolger would act as delegate for Waukesha.

A motion of Doctor McGreane, seconded and carried, the attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 91 as compiled by the Credentials Committee, was accepted as the official roll of this session of the House of Delegates.

G. A. BEHNKE, M.D., DONALD M. RUCH, M.D., P. E. OBERBRECKLING, M.D.

ANNOUNCEMENT OF REFERENCE COMMITTEE APPOINTMENTS

Speaker Nordby appointed the following reference committees:

Reference Committee on Reports of Officers
R. S. Gearhart, M.D., Madison, Chairman
G. W. Hilliard, M.D., Milwaukee
L. W. Schrank, M.D., Waupun
J. F. Walsh, M.D., Port Washington
P. T. Bland, M.D., Westby

Reference Committee on Reports of Standing Committees
R. M. Waldkirch, M.D., De Pere, Chairman
H. W. Carey, M.D., Lancaster
A. J. Sanfelippo, M.D., Milwaukee
F. E. Gehin, M.D., Stevens Point
E. W. Humke, M.D., Chilton

E. J. NORDBY, M.D.

E. D. SORENSON, M.D.

Reference Committee on Resolutions and Amendments to the Constitution and Bylaws
Edgar End, M.D., Milwaukee, Chairman
L. J. Kurten, M.D., Racine
I. L. Blose, M.D., Durand
C. J. Picard, M.D., Superior
R. G. Zach, M.D., Monroe

MINUTES OF 1960 SESSIONS APPROVED

A motion of Dr. E. A. Strakosch, Oshkosh, seconded by Dr. E. W. Humke, Chilton, and carried, proceedings of the 1960 regular sessions of the House of Delegates as printed in the September 1960 issue of the *Wisconsin Medical Journal* were approved.

STANDING RULES ADOPTED

On motion of Dr. L. O. Simenstad, Osceola, seconded by Dr. E. A. Strakosch, Oshkosh, and carried, the standing rules of procedure as stated on page 3 of the House of Delegates Calendar were adopted as the standing rules of this session of the House of Delegates.

REPORTS OF OFFICERS

Report of the President

President E. D. Sorenson (Elkhorn): It gives me pleasure to stand before you again and to tell you that this past year as your President has been an enjoyable one. It has been truly educational, and an experience which I can state is one that I am very happy to have had.

I have found the membership throughout the State to be extremely cooperative. I cannot thank all the members of the Council, the various committee members, the county officers and the members of our valiant staff in any manner appropriate to their activities, so I will simply say "thank you" to all of them.

The past year has seen twelve meetings of the Executive Committee and four of the General Council, plus many others of various committees and commissions.

The committee structure of your Society has functioned in a highly satisfactory manner, as you will discover upon the reading of their various reports. These gentlemen are to be complimented for their efforts. I can certainly testify to their sincerity of purpose in their meetings, as I have attended many of them.

Your Commission on Medical Care Plans has truly done a wonderful job this past year. This is evidenced by the monthly reports that have been submitted. We have come from the red side of the ledger to the deep black, to the tune of thousands of dollars. This trend was prognosticated by your actuaries one year ago, and you can be very grateful that it has been accomplished.

The legislative program this year is a colossal one. I am very grateful for the response of the general membership in helping to solve some of the many problems. Probably the most important of the programs was the defeat of the Forand bill and the passage of the substitute Kerr–Mills bill.

For the past five months your Society and staff have been diligently at work in formulating legislation that would permit us as a State to take part in the benefits to be provided under this bill.

Progress has been slow, we will admit; but this bill is of such magnitude that it could not be implemented except by exhaustive study. Progress has been made, and I can assure you that your Society has not been indifferent to the importance of the position it should maintain for the benefit of our people.

Many hours of work and many meetings have been held in the development of a program that would satisfy, at least to some degree, the State Legislature and the Department of Public Welfare as well as the State Medical Society. This is a State project and must of necessity come under the direction of the public Welfare Department; therefore, it is a community project and is best solved by the action of all departments concerned, and in a harmonious manner.

Another very important development has been the Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959, relating to fee splitting between physicians and others. This Guide was prepared by the Commission on Hospital Relations and Medical Education and approved by your Council. It probably is not perfect, and may not satisfy all concerned, but at least it points the way and gives all of us the proper directional signals.

As to your Charitable, Educational and Scientific Foundation, the Museum at Prairie du Chien was dedicated and opened to the public for two months in the fall of 1960. During this time the Museum was visited by nearly 6,000 people. It opened its 1961 season yesterday. Within a few years this will become one of the most popular museums in the Midwest.

The Medical Student Loan Fund has done a tremendous job since its inaugural. At the present time we have helped or are helping some seventy to eighty boys in starting or completing their medical courses. I wish to state to the House that at the present time this Fund is about broke. We need very badly more contributions from our membership. This program is a very noble venture, and if we want to continue helping our boys through their medical education we must carry our load. You can earmark your donation to the Student Loan Fund if you wish. This is a very worth-while program that should be implemented with all possible means by each county society.

While I have stressed the Museum of Medical Progress and the Student Loan Fund, there are many other valuable activities of the Foundation. Here and now I want to record our gratitude to those who had the vision to seek the organization of the Foundation and give it its initial start.

Much work is being done in the present session of our State Legislature. Your State Legislative Committee has been and is very active, as there are many bills introduced which have a bearing on medical practice. It is anticipated that we will be quite successful in opposing some and defending others. I can assure you that many hours have gone into the reading and interpretation of the various bills.

Gentlemen of the House of Delegates, once again I want to say that it has been an honor and a pleasure to have served as your President. If I have accomplished anything, that is for you to say. I have tried at least to preserve and promote good public relations. How well I have succeeded remains to be seen.

Thank you all for your fine cooperation. That was what I asked for one year ago, and I can honestly say that I have been rewarded.

Report of the President-Elect

The report of the president-elect, Dr. Leif H. Lokvam, Kenosha, was published in the June issue of the *Wisconsin Medical Journal.*

President-Elect Committee Appointments

Committee appointments for standing committees as recommended by the president-elect, Doctor Lokvam, were approved on motion of Dr. E. A. Strakosch, Oshkosh, severally seconded.

Committee on Cancer

Dr. J. W. Boren, Jr., Marinette (reappointed); Dr. M. W. Stuessy, Brodhead; and Dr. G. H. Williams, Marshfield. Dr. Paul Cunningham, Appleton, was reappointed to serve as chairman.

Commission on Public Policy

Dr. J. F. McIntosh, Madison. Dr. R. G. Zach, Monroe, was designated to serve as chairman.

Committee on Grievances

Dr. H. J. Belson, Manitowoc (reappointed); Dr. R. R. Richards, Eau Claire (reappointed); and Dr. T. J. Nereim, Madison. Dr. E. D. Sorenson, Elkhorn, was designated chairman.

Commission on Public Relations and Communications

Dr. D. M. Willison, Eau Claire (reappointed); Dr. J. S. Devitt, Milwaukee (reappointed); and Dr. Louis Olsman, Kenosha. Doctor Willison was reappointed chairman.

Commission on Scientific Medicine

Dr. G. W. Collentine, Jr., Milwaukee. This Commission selects its own chairman.

Commission on Hospital Relations and Medical Education

Dr. C. J. Picard, Superior (reappointed); Dr. G. B. Murphy, Jr., La Crosse; and Dr. Edgar End, Milwaukee. Dr. R. S. Gearhart was reappointed chairman.

Report of the Council

The report of the Council was published in the July issue of the *Wisconsin Medical Journal.*

A SERIOUS DISCUSSION

GEORGE SCHWEI, M.D., A. J. McCAREY, M.D., GORDON SCHULZ, M.D., W. D. STOVALL, M.D., AND UNIDENTIFIED REGISTRANTS

Report of the Treasurer

The report of the treasurer, Dr. F. L. Weston, Madison, was published in the July issue of the *Wisconsin Medical Journal.*

Report of the Secretary

Two physicians' names were added to the Necrology Report which was published in the July issue of the *Wisconsin Medical Journal.* They were Dr. A. T. Smedal of Stoughton and Dr. Arthur Raymond of Milwaukee.

INTRODUCTION OF GUESTS

Speaker Nordby introduced the following guests: Dr. Otto N. Glesne, president of the Iowa State Medical Society; Mr. Ralph Sett, president-elect of the Marquette Chapter of the Student American Medical Association; Mrs. S. H. Ambrose, president, and Mrs. J. Howard Johnson, president-elect, of the Woman's Auxiliary to the State Medical Society.

REMARKS OF PRESIDENT OF WOMAN'S AUXILIARY

Mrs. S. H. Ambrose (Whitewater): I bring you greetings from your medical Auxiliary. I am not used to speaking in front of men. It doesn't bother me at all to speak to a group of women, but this reminds me of the time I spoke to the Legislature in Washington. I was scared to death then, too.

Legislation has been the paramount project of the Auxiliary during my term of office. The thirty-six county auxiliaries in Wisconsin have wholeheartedly given their support and worked diligently in their districts informing their legislators of their views on bills concerning medicine.

Personal letters were written to our congressmen in Washington and to our State senators and assemblymen. The women worked many hours before the national election to help elect members to Congress who would effectively represent medicine and support the Kerr–Mills bill. In many districts they succeeded. I carried the message of the Kerr–Mills bill in my talks to the 24 county auxiliaries which I visited this past year. The response was dynamic. Almost every one of our 1,800 members wrote letters to their congressmen urging them to support the bill.

"Wisconsin's Medical Heritage" is the theme for this State convention, in keeping with the National Auxiliary's theme of "Preserve and Enhance the Heritage of American Medicine". It also fits in well with the challenge given us by you to assist with the Museum of Medical Progress at Prairie du Chien. The sum of $250 was contributed to the Museum to initiate a program of research on the role women have played in Wisconsin's history of medicine.

Doctor Hildebrand requested our members to participate in the Heart Campaign. Our help was significant, and the Auxiliary has been petitioned to sponsor the 1962 Heart Drive.

Rural health has been added to our State committees. Over $5,000 was raised for the American Medical Education Foundation. "Operation Santa Claus" was again executed successfully by the Mental Health Chairman.

Scholarships for girls entering nurse's training was a major project of several of the auxiliaries, and $500 will be given to your President at our luncheon tomorrow for the Wisconsin Charitable, Educational and Scientific Foundation.

I am convinced that the State Medical Auxiliary could not function without the services of Mrs. Chesemore. She is our guiding light. I take this opportunity to thank the State Medical Society for her services, and for the publication of the *Badger Doctor's Wife.* Also, I wish to express my appreciation to your members for making it possible for my husband and me to attend the AMA Legislative Conference at French Lick Springs last August.

Do drop into our booth at the Auditorium and view our display while you sip a cup of coffee and purchase a copy of "Gifts, Gadgets and Glamor" for your wife.

STATEMENT REGARDING DUES FOR THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION

In the absence of the president of the Foundation, Dr. W. D. Stovall, Madison, Mr. Charles H. Crownhart, secretary, reported that the Executive Committee of the Foundation had approved the following recommendation:

> That the voluntary billing of Society members be sent with no amount stated, inasmuch as it was felt that some do not wish to send the $10 and consequently do not return the billing at all, when actually any amount would be gladly received, while others are able and willing and some do send more.

It was recommended to the House that the voluntary billing be simply that with no amount stated.

INTRODUCTION OF GUEST

Dr. Hugh Williams of Minnesota, a 50-year graduate of Marquette, Class of 1911, was introduced to the House.

REPORT OF STATE HEALTH OFFICER

Dr. Carl N. Neupert (Madison): The invitation to present in a very few minutes the "affairs of the State Board of Health" is like having one fond grandmother ask another about her grandchildren, only to be confronted with the question in reply, as she fondled her purse bursting with treasured snapshots, "How much time have you got?"

Many of you are not aware that to carry out the Board's affairs we have over thirty separate units in our department, dealing with a variety of such matters as preventable diseases, sanitary engineering, maternal and child health, chronic disease and aging, as well as licensing of nursing homes, of barber shops and plumbers, to mention a few. In all, the purpose is that of preventing disease and promoting health.

Currently the most pressing public health problems could probably be listed as those having to do with our "population explosion"—almost 100,000 births last year, the highest number on record; water supply and waste disposal problems associated with urbanization (moving to expanding cities and to suburbs); an aging population with its chronic disease and other accompaniments, and the emergence of new virus diseases.

As practicing physicians and guardians of the health of your individual patients, you are also involved in all of these and many others together with the Board. Over the years there has been close cooperation, you with your individual patients and we with the community or general aspects, working together.

Some of you have been concerned that we, as an official agency, were getting into the practice of medicine. Concern has been expressed that screening of apparently well people by way of our three x-ray buses that cover the State once in two and a half years, and that include screening for hypertension, is beyond our role as a public agency.

First, hypertension screening is omitted in counties in which the county medical society does not approve it, since results are dependent on the follow-up by the attending physician. Second, such a screening process does not involve a diagnosis on our part.

We suggest to the screenee, whose blood pressure reading was above the maximum set, that at the time he visited the bus there was indication that it would be well for him to see his family physician. We neither diagnose nor treat anyone.

There has been a further refinement out of experience, namely, only those who indicate they are unaware of any heart disease or hypertension are referred to their physician. Substantial numbers of persons coming to the buses who were unaware of their hypertension have been benefited as a result of treatment instituted by you, their physicians, as a result of the screening program.

Most of you see in this a step forward in promoting the health of people, your patients, without any threat to your essential patient-physician relationship or to the practice of medicine.

Policy is established by the Board, all but one of whom are physicians. They carefully consider and weigh their responsibilities as citizens in their official capacity. The Board is aware that unless it meets its responsibilities with regard to the public health aspects of an aging population, the population explosion, and so forth, other means might well be found to meet them that could not do as well.

The Board meets regularly every month, is well informed prior to each meeting as to the pros and cons of matters coming before it, and puts in many hours of consecrated public service in meeting its comprehensive responsibilities of safeguarding the health of us all. Some of its major public health activities in noncommunicable disease fields are listed on the back page of the annual meeting program.

This brief report of the affairs of the Board is not about any favorite grandchildren, but the same question is involved: "How much time have you got?"

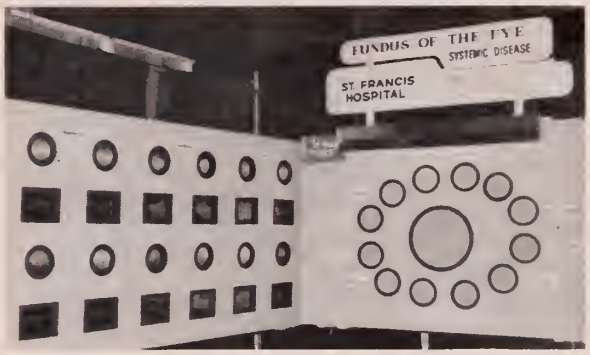
COMMITTEE ON NOMINATIONS

The result of the caucus for members of the committee on nominations was reported as follows:

First District_____L. W. Schrank, Waupun
Second District_____J. E. Martin, Jr., Delavan
Third District_____P. B. Golden, Madison
Fourth District_____W. D. Hamlin, Mineral Point
Fifth District_____W. A. Nielsen, West Bend
Sixth District_____D. J. Twohig, Jr., Fond du Lac
Seventh District _____E. P. Rohde, Galesville
Eighth District_____C. E. Koepp, Marinette
Ninth District_____M. V. Overman, Neillsville
Tenth District_____H. F. Pagel, Ladysmith
Eleventh District_____C. J. Picard, Superior
Twelfth District_____G. E. Collentine, Milwaukee
Thirteenth District_____W. P. Curran, Antigo

ADJOURNMENT

The first session adjourned at 10:10 p.m.



SCIENTIFIC EXHIBIT WINNER—Placing first in the small hospital class at the annual meeting was the St. Francis Hospital, Milwaukee, exhibit on "The Fundus of the Eye in Systemic Diseases." The exhibit was made by the Department of Internal Medicine.

St. Joseph's Hospital, Milwaukee, placed second with the exhibit "Necrotizing Papillitis—Roentgen Findings" by Drs. Arthur Fitz, James Lee, J. F. Wepfer, and G. W. Sengpiel.

Third place was awarded Drs. R. W. Mann and M. E. Sattler of the Mt. Sinai Hospital, Milwaukee, for their exhibit on "Routine Operative Cholangiography."

CORRECTION!

In the July issue of the *Wisconsin Medical Journal*, page 425, House of Delegates' Reports, an error was made in the report of the Commission on State Departments. In the section on "Standards for Tuberculosis Testing," No. 2 should have read: "The recommended test done should be .0001 mgm.," instead of ".001 mgm."

SECOND SESSION

Tuesday, May 2, 1961

The second session of the House of Delegates reconvened at 7 p.m., Dr. E. J. Nordby, Speaker of the House of Delegates, presiding.

REPORT OF COMMITTEE ON CREDENTIALS

Dr. N. A. McGreane, Darlington, chairman of the Committee on Credentials, reported the registration of 68 delegates and 5 alternate delegates entitled to vote at this second session of the House of Delegates. Doctor McGreane moved, seconded and carried, that the attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 73 as compiled by the Credentials Committee, be accepted as the official roll of this second session of the House.

MANAGEMENT SURVEY COMMITTEE

Speaker Nordby announced the members of the Management Survey Committee which was authorized under a resolution passed by the House in 1960. They are:

Dr. H. M. Suckle, Madison, Chairman
Dr. L. W. Schrank, Waupun
Dr. J. W. Boren, Jr., Marinette
Dr. R. W. Ashley, Kenosha
Dr. Edgar End, Wauwatosa
Dr. J. P. Conway, Milwaukee

REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS

Dr. R. S. Gearhart, Madison, presented the report of the Reference Committee on Reports of Officers. Actions of the House and comments of the Reference Committee are as follows:

1. Report of President, page 510 of this issue of the *Wisconsin Medical Journal*—accepted. Doctor Sorenson was commended for his review of the past year and his efforts in behalf of good public relations as the chief aim of his office.

2. Report of President-Elect, page 319 of June issue—accepted, including committee appointments. The Committee reviewed with satisfaction the remarks made by Doctor Lokvam with his plea that medicine stand against the growth of personal security at any cost as the idolatrous golden calf in American life.

3. Report of Treasurer, page 412 of July issue—accepted. The Committee recommended that succeeding reports include an organizational explanation of the relationship of the various divisions and corporations to the parent Society.

4. Reports of Council, page 398 of July issue—accepted, with exception of those items in the supplementary report referred to the Reference Committee on Resolutions and Amendments to the Constitution and Bylaws. The Committee commended the outstanding accomplishments of Dr. G. S. Kilkenny upon his resignation from the Division on Maternal and Child Welfare after five years of service.

5. Report of Wisconsin Delegates to the American Medical Association, circulated to every member of the Society and published in the *Wisconsin Medical Journal*—accepted with commendation.

6. Report of Commission on State Departments, page 418 of July issue—accepted, including supplementary reports. The 11 recommendations made by the Commission as listed in the report were also accepted.

G. W. HILLIARD, M.D., J. F. WALSH, M.D., P. T. BLAND, M.D., R. S. GEARHART, M.D.

7. Report of Committee on Health Economics of American Life, page 410 of July issue—accepted.

8. Resolution No. 10, introduced by Douglas County Medical Society, relating to tuberculosis and tuberculosis hospitals, page 432 of July issue—accepted as amended. The amendment is as follows: The 11th and 12th "Whereases" were deleted and the "Resolved" changed to read:

> "*Resolved,* That the House of Delegates of the State Medical Society of Wisconsin direct the officers and the Council of the State Medical Society of Wisconsin, through the Division on Chest Diseases of the Commission on State Departments, to enlist the aid of the appropriate legislative and executive branches of the State of Wisconsin to formulate *a plan of study* of State tuberculosis control that should result in definite recommendations based upon a complete and adequate study of both State and county tuberculosis control."

9. Report of State Board of Health, page 513 of this issue—commended Dr. Carl N. Neupert, State Health Officer, for his continuing close cooperation with and assistance to the private practice of medicine.

10. Report of Woman's Auxiliary, page 512 of this issue—commended the organization for its devotion and efforts on behalf of the Society.

REPORT OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

Dr. R. M. Waldkirch, DePere, presented the report on behalf of the Reference Committee on Reports of Standing Committees. Actions of the House and comments of the Reference Committee are as follows:

1. Commission on Scientific Medicine, page 412 of July issue—accepted.

2. Commission on Hospital Relations and Medical Education, page 415 of July issue—accepted with the suggestion that delegates discuss with their county medical societies the good that could be done by individual physicians hiring medical students as assistants during the summer months, which would provide a form of preceptorship, would provide income for these students, and probably would also interest many of them in general practice. This suggestion resulted from an announcement that more than 130 medical students had applied for employment this summer at the State Society office.

3. Committee on Disaster Medical Care—page 406 of July issue—accepted.

4. Committee on Military Medical Service, page 408 of July issue—accepted.

A. J. SANFELIPPO, M.D., R. M. WALDKIRCH, M.D., H. W. CAREY, M.D., E. W. HUMKE, M.D., F. E. GEHIN, M.D.

5. **Committee on Cancer**, page 407 of July issue—accepted.

6. **Committee on Clinical Medicine**, page 408 of July issue—accepted.

7. **Committee on Grievances**, page 410 of July issue—accepted. The Committee urged physicians to again read its 1960 report as printed in the *Wisconsin Medical Journal*, July 1960, and to consider carefully the suggestions made therein, attempting to eliminate grievances at their source. It was brought out that another substantial number of problems might be eliminated if county medical societies were to make the local Bar Associations aware of the availability of the Grievance Committee mechanisms. The Committee urged physicians to re-read the Interprofessional Code (printed in the January 1960 issue of the *Wisconsin Medical Journal*, and distributed in booklet form upon request).

8. **Commission on Public Relations and Communications**, page 415 of July issue—accepted.

9. **Resolution No. 11**, introduced by Douglas County Medical Society, to seek a partial solution to the many problems relating to the field of general practice, page 432 of July issue—referred to the Commission on Hospital Relations and Medical Education for a more detailed study and recommendation by the State Society to the American Medical Association, and a recommendation made by them to the State Medical Society.

INTRODUCTION OF GUEST

Speaker Nordby introduced the following guest: Dr. C. L. Oppegaard, of Crookston, Minnesota, president of the Minnesota State Medical Association.

REPORT OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

Dr. Edgar End, Milwaukee, reported on behalf of the Reference Committee on Resolutions and Amendments to the Constitution and Bylaws as follows:

1. **Supplementary Report of Council**, page 399 of July issue—accepted statements regarding personal service corporations, health assistance to the aged, public policy resolutions, and the resolution on social security health care. It accepted the resolution regarding county medical society speaking programs with the addition of the following phrase as part of the last sentence: ". . ., and that all members be urged to participate actively in all community activities within their geographical area."

2. **Commission on Medical Care Plans**, page 428 of July issue—accepted with commendation for the careful supervision which has brought about a much-improved financial status in the programs under its direction.

3. **Foundation**, circulated by hand to members of the House of Delegates—accepted the report relating to the deletion of the specific amount of $10 included on the voluntary billing to Society members.

4. **Commission on Public Policy**, page 404 of July issue—accepted.

5. **Resolution No. 1**, introduced by Dane County Medical Society, page 431 of July issue—accepted with the insertion of the word "acceptable" in the first "Resolved" clause, which then read: "That these acceptable nonmember physicians be expressly invited to join and participate in the activities of their county medical society and in the State Medical Society of Wisconsin;".

6. **Resolution No. 2**, introduced by Dane County Medical Society, was combined for review with Resolution No. 9 of the Sixth Councilor District, with consent of both sponsoring members, pages 431 and 432 of July issue—not accepted in original form. The following substitute resolution was accepted:

> "WHEREAS, under the present Bylaws of the State Medical Society of Wisconsin there is no limitation of tenure of office and of committee memberships and commission memberships held by members of the State Medical Society at all levels of the Society, and
>
> "WHEREAS, significant criticism and unrest have been noted among the rank and file of members of the State Medical Society of Wisconsin concerning such limitless tenure, and
>
> "WHEREAS, it is felt by many and has become axiomatic that there is no 'indispensable man' in society; therefore, be it
>
> "*Resolved*, that this House of Delegates does now duly instruct the legal counsel, in cooperation with the staff of the State Medical Society, to draft such changes in the Bylaws to limit tenure of office and committee membership and commission membership, with the exception of delegates to the American Medical Association, to three consecutive terms; and be it further
>
> "*Resolved*, that such draft be submitted to the next regular or special meeting of the House of Delegates for consideration."

7. **Resolution No. 3**, introduced by Dane County Medical Society, page 431 of July issue—not accepted in original form. The following substitute resolution was accepted:

> "WHEREAS, the county medical society is the basic unit of the State Medical Society of Wisconsin; therefore, be it
>
> "*Resolved*, that appointments to State Medical Society offices should, insofar as is practicable, be cleared with an appropriate representative of the county medical society of which the appointee is a member."

8. **Resolution No. 4**, introduced by Dane County Medical Society, page 431 of July issue—not voted on inasmuch as the intent of the resolution was carried out by Dr. E. J. Nordby who appointed a committee as authorized by the 1960 House of Delegates.

9. **Resolution No. 5**, introduced by Dane County Medical Society, page 431 of July issue—accepted with commendation and appreciation to Dr. Edward Annis and with an amendment to show him as a graduate of Marquette University School of Medicine. This amendment was added at the end of the first line, after the words "Miami, Florida".

10. **Resolution No. 6**, introduced by Columbia–Marquette–Adams County Medical Society, page 431 of July issue—not accepted in its original form because of its effort to establish a set fee for service. The resolution was accepted following an amendment of the "Resolved" clause which read:

R. G. ZACH, M.D., EDGAR END, M.D., I. L. BLOSE, M.D., L. J. KURTEN, M.D.

"*Resolved*, that the use of standard report forms be encouraged and that a fee commensurate with the work involved be charged for the completion of such reports."

11. Resolution No. 7, introduced by Brown County Medical Society, page 431 of July issue—rejected with commendation to the AMA delegates for their wisdom and judgment.

12. Resolution No. 8, introduced by the Sixth Councilor District, page 432 of July issue—accepted.

13. Resolution No. 12, introduced by Monroe County Medical Society, page 433 of July issue—rejected on the basis that professional relationships at the local level will accomplish as much as is proposed in this resolution, and the additional efforts planned by the State Medical Society will include the aims of this resolution.

14. Resolution, submitted by the Reference Committee on Resolutions—accepted. The resolution is as follows:

"WHEREAS, it is reported that the General Assembly of the United Presbyterian Church, meeting in Buffalo, New York, May 14–23, will consider a resolution to endorse health care of the aged via social security, and

"WHEREAS, it is also reported that the YWCA meeting in national convention in Denver, Colorado, May 6–7, will consider a recommendation to its Board of Directors to support health care of the aged through compulsory social security; therefore, be it

"*Resolved*, that the officers and delegates of this Society and the individual members of the Society take immediate steps beginning today to personally express medicine's viewpoint on these issues to the Presbyterian ministers and elderly in Wisconsin, and to the leadership of each YWCA unit in this State, and especially to the delegates of each of these groups to their respective assemblies; and be it further

"*Resolved*, that the leaders of these groups be urged to introduce resolutions at their meetings supporting the Kerr–Mills approach and opposing social security or other methods of compulsory financing of health care."

15. Dues for 1962. Accepted an increase in dues for 1962 of $15 instead of the recommended increase of $25. This makes the total yearly dues $90.

REPORT OF SECRETARY OF STATE BOARD OF MEDICAL EXAMINERS

Dr. T. W. Tormey, Jr. (Madison): All of you have heard or read about the problem of needing more doctors in this State. The lay press and the *Wisconsin Medical Journal* have carried articles indicating that our newly licensed physicians are equal to 2.8 per 100,000 population as compared with the national average of 4.6.

What the basis is for these figures, I am sure I don't know, since we expect to license between 325 and 350 physicians a year in Wisconsin, and this gives us about eight per 100,000. I assume the difference in these figures is due to the fact that, of this group, approximately 64 go into residency training, and annually we endorse approximately 200 physicians to other states—about 25 per cent of these latter plan to hold the additional license in reserve for possible future use.

The shortage of house staffs in hospitals approved for residency training has been somewhat relieved by our planning. This, as you know, resulted in the Temporary Educational Permit law of 1954 which allowed certain foreign graduates to take residency training in this State. Over-all, the program has been highly successful. Of course, now the ECFMG has entered the picture in an effort to improve the quality of the foreign graduates selected in these positions. At the present time there are 100 foreign graduates training beyond the internship year in this State.

Over the past five or six years we have been gratified to see the program of licensing foreign graduate American-trained physicians develop from a cautious and skeptical entity into a workable and recognizable procedure. No little part of this program has been due to the fine cooperation and advice we have received from the State Medical Society and the Deans of our two Medical Schools. Over the years many hours of consultation, advice and help have resulted in what we consider an excellent device for screening and evaluation.

Through the program we feel this State has gained a group of medical men and women of whom we can be proud. Since 1956 this group has become 96 in number. You may wonder where the licensed foreign graduate doctor goes. Some have gone into State institutional service, some into clinic groups, some to small towns, and others into areas of various nationality concentrations. In other words, they go everywhere in the State, the same as our American graduates; but, more important, they go where their services are requested and needed, as required by a Board ruling.

About two months ago we came very near losing up to 18 or 20 of our allowed annual quota of foreign graduates, which is 25. You may have noted in news releases that a change had been made in the State law to allow licensing of foreign graduates who otherwise qualified and who had no citizenship status but who had a special act of Congress. Special acts of Congress, in such instances, happen only once in 20 to 25 years.

In making the change our legislators, without effective consultation with the Board of Medical Examiners or the State Medical Society, cut out the provision for those holding a Declaration of Intent to become citizens. Consequently, as soon as this was discovered, an amendment was introduced to reinstate the above provision.

Other legislative changes are being sought for the Medical Practice Act to bring it up to present-day needs. Most such changes will be of an administrative nature. Among what we consider of major importance is granting the Board legal mechanisms

by which a licensee may be placed on probationary status, or that problem cases may be subject to temporary suspension of the license where justified.

Presently we are required to suspend or revoke licenses following verified conviction in a circuit or federal court of actions prohibited under 147.20, Wis. Stats. Experience by the Board suggests that this proposed authority will expedite the handling of problem cases and do it without undue or harmful publicity. At the present time Wisconsin is one of five or less states that lack such authority in its medical licensing group.

At the April meeting of the Board we learned another reason why we are fortunate in being in this State. Mr. William Wanzeck, the new District Treasury Agent in charge of the Narcotic Division, told us we are considered a "clean" State—meaning, of course, that physician addiction is not a major problem. We were informed, however, that there are 10 and possibly 15 physicians whose narcotic orders are being investigated at this time. On a national basis, the average is that one in 200 physicians are users of narcotics.

Since 1953 the registration of physical therapists will have gone from an initial group of 144 under the so-called "grandfather clause" to about 500. Because this group is increasingly more closely associated with us in medicine, we are including them in the Registry for the first time this year.

Many other interesting facets of our Board's work could be mentioned, but I wish at this time to thank you for allowing the above presentation.

INTRODUCTION OF GUEST

Mr. Charles Johnson, of the Field Service of the AMA, who services this area of the United States, was introduced.

ADJOURNMENT

The second session adjourned at 8:20 p.m.

THIRD SESSION

Wednesday, May 3, 1961

The third session of the House of Delegates reconvened at 9:15 a.m., Dr. E. J. Nordby, Speaker, presiding.

REPORT OF COMMITTEE ON CREDENTIALS

Dr. N. A. McGreane, Darlington, chairman of the Committee on Credentials, reported the registration of 59 delegates and 4 alternate delegates entitled to vote at this third session of the House of Delegates. A motion of Doctor McGreane was seconded and carried that the attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 63 as compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

INTRODUCTION OF GUEST

Speaker Nordby introduced the following guest: Dr. W. S. Jones, past president of the Michigan State Medical Society.

AT HOUSE OF DELEGATES SESSION

SPECIAL PRESENTATION

Dr. E. M. Dessloch, Prairie du Chien, on behalf of the House of Delegates, presented a gold coin from his collection to Mr. Charles Crownhart who at this session was completing his 20th annual meeting as secretary of the State Medical Society.

REPORT OF COMMITTEE ON NOMINATIONS

Dr. C. J. Picard, Superior, chairman of the Committee on Nominations reported the following nominees for the official positions in the State Medical Society of Wisconsin and they were accepted by the House:

President-elect—Dr. Nels Hill, Madison

Speaker of the House—Dr. Robert Callan, Milwaukee

Vice Speaker of the House—Dr. H. W. Carey, Lancaster

Delegate to the American Medical Association to succeed Dr. A. A. Quisling—Doctor Quisling, Madison

Delegate to the American Medical Association to succeed Dr. Roman Galasinski—Doctor Galasinski, Milwaukee

Alternate Delegate to the American Medical Association to succeed Dr. W. B. Hildebrand—Doctor Hildebrand, Menasha

Alternate Delegate to the American Medical Association to succeed Dr. George E. Collentine, Jr.—Doctor Collentine, Milwaukee

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Location of the next Annual Meeting of the State Medical Society was selected as Milwaukee.

ELECTION OF COUNCILORS

The House elected the following Councilors:

Third District—to succeed Dr. N. A. Hill, Madison—Dr. E. J. Nordby, Madison

Fourth District—to succeed Dr. E. M. Dessloch, Prairie du Chien—Doctor Dessloch

Fifth District—to succeed Dr. P. B. Blanchard, Cedarburg—Doctor Blanchard

Sixth District—to succeed Dr. H. J. Kief, Fond du Lac—Doctor Kief

Twelfth District—to succeed Dr. J. P. Conway, who declined renomination, Milwaukee—Dr. Donald M. Willson, Milwaukee

Twelfth District—to succeed Dr. George S. Kilkenny, whose resignation was accepted, Milwaukee—Dr. William J. Houghton, Milwaukee

REPORT ON AMERICAN MEDICAL EDUCATION FOUNDATION

Dr. A. H. Heidner (West Bend): I don't know if our honored guests will be interested in this talk or not, but they may listen without any extra charge if they wish. [Laughter]

If you buy a newspaper today you might find this announcement in it:

"MILWAUKEE—Wisconsin's two medical schools today received $28,039.42 from physicians of America.

"The money was contributed through the American Medical Education Foundation, which was established by the American Medical Association.

"Accepting a check for $16,442.91 was John S. Hirschboeck, M.D., Dean of the Marquette University School of Medicine.

"John Z. Bowers, M.D., Dean of the University of Wisconsin Medical School, received a check for $11,596.51.

"The presentations were made by A. H. Heidner, M.D., West Bend, Chairman of the State Medical Society of Wisconsin's AMEF Committee, as a special feature of the annual meeting of the Society currently being held in Milwaukee.

"The grants bring to $59,548.66 the amount Marquette University has received from AMEF in the past five years. The five-year total for the University of Wisconsin is $52,257.59.

"Each grant included $5,207.32 from the general fund of the AMEF and the remainder was made up of physicians' contributions designated for the specific medical schools.

"No restriction is put on the use of the grants, except that they be considered over and above the budgeted program of the school, to be used where adequate funds would otherwise not be obtained.

"AMEF grants represent but a portion of the money contributed annually by physicians to medical schools. In addition to their AMEF grants, the State's medical schools last year received $114,369.15 in direct gifts from their alumni."

This is my annual report as State Chairman of the American Medical Education Foundation:

As I have told you in previous years, I have come home each year from the State Chairmen's meeting in Chicago full of pep and ambition to put on a drive for funds for the AMEF.

I have heard there about the need of the medical schools for funds, and the importance of supporting them by contributions from doctors and lay people to keep medical education out of the hands of the government.

When I got home I realized that our doctors were being urged to support the important projects of our own State Medical Society, such as the Charitable, Educational and Scientific Foundation, its Student Loan Fund, the Museum at Prairie du Chien, and then the Middleton Library Fund.

All of these projects are important to medical education, and it seemed disloyal to put on any kind of a vigorous campaign, as has been done in other states, in competition with them.

The situation brightened up last year. The projects mentioned were going along quite well under their own power, and the Council was induced to provide some money to help a committee appointed by Doctor Stovall, Chairman of the Charitable, Educational and Scientific Foundation, to put on a modest campaign for funds for the AMEF. This was done mostly through the efforts of our ever-faithful and competent Roy Ragatz.

This solicitation for contributions was made chiefly through the deans of our two medical schools. They wrote to their alumni residing in Wisconsin to write their gifts to Marquette University and the University of Wisconsin Medical Schools through AMEF.

The deans of medical schools in several surrounding states also wrote their alumni living in Wisconsin to do likewise.

By this effort we have doubled Wisconsin's contribution to AMEF from the previous average of around $8,000 to $16,466.

This is very gratifying, but is still far less than it should be.

In 1959 only 9.2 per cent of our 3,444 physicians in Wisconsin contributed to AMEF. This percentage was raised to 14 per cent in 1960. Wisconsin is eleventh in the United States in the number of physicians practicing in the states, and was forty-seventh in the number of physicians contributing. We were eighteenth in size of the average contribution.

Of the $16,000 contributed last year, the Woman's Auxiliary of Wisconsin contributed almost $6,000.

The average contribution in 1959 was $37. In 1960 it was $68. Analysis of these figures means that by some means or other many more doctors should be contacted and become interested in supporting their medical schools.

Everyone knows that with our rapidly increasing population many more doctors will be needed. This means that more and larger schools must be provided.

Corporations and lay funds that are able to contribute have expressed interest and concern in what the doctors give toward medical education, and gauge the amount of their gifts in proportion to the AMEF fund.

The reason I am reporting to you is because you delegates are the group who can carry this message home to your constituent county societies and best reach the largest number of physicians.

Please remember the following points:

1. Every dollar given to AMEF goes to medical education, as the AMA pays all overhead expenses.
2. Funds given to medical education are unrestricted and can be used by the deans where needed the most.

Yesterday I attended a meeting of the Wisconsin Alumni Association, and Doctor Bowers reported some millions of dollars that he is going to receive for the University of Wisconsin Medical School. This contribution today seems a pittance, but those millions of dollars are going to go into the brick and mortar, and the money AMEF gives he can use wherever it is needed, whenever an emergency arises or if there is a shortage that arises. It has been suggested several times that this money be called the Dean's Fund, because from letters AMEF receives from deans they appreciate this money more than they can say.

3. All contributions to AMEF are tax-exempt.
4. The amount of money given to AMEF largely influences the amount laymen and lay organizations will contribute.
5. Medical schools approve your routing all of your contributions through AMEF.

Please carry this message home with you to your society members, and don't forget to give, yourself.

Doctor Bowers and Doctor Hirschboeck, it is a great honor for me to be able to make this contribution to you and your Medical Schools.

SCIENTIFIC EXHIBIT WINNER—Dr. J. D. Hurley of the Department of Surgery, Milwaukee County Hospital, was winner of the first place award in the large hospital classification for the scientific exhibit entitled "Approaches to Cancer Chemotherapy," pictured above.

Second place was won by Dr. Lucille B. Glicklich, Milwaukee Children's Hospital, for the exhibit "Developmental Evaluation of the Infant in the First Four Months of Life." Third place went to the Radioisotope Service of the Veterans Administration Center, Wood, for the exhibit entitled "The Radioisotope Renogram."

REMARKS OF DEAN OF MARQUETTE UNIVERSITY SCHOOL OF MEDICINE

Dr. John S. Hirschboeck (Milwaukee): Again it is a pleasure for me to be able to come before you to give an annual report of important things which have gone on in the past year and which we are planning for the future in Marquette University School of Medicine.

First, I would like to call your attention again to the fact that one of the great needs not only of our Medical School but of all medical schools in the United States is to have in the background an ever-expanding reservoir of interest among our young people for considering medicine as a career.

This problem is particularly acute, I believe, in our own State. The number of young people who are interested in studying medicine seems to be steadily declining, and it is the duty of the medical profession and of the medical schools to reverse this trend and reverse it rapidly and with enthusiasm.

A recent publication of the *Journal of Medical Education,* in which a statistical analysis of many things is made, in one analysis which relates the population of a state to the number of applicants for medical school in that state regardless of which medical school they apply to in the United States, reveals that Wisconsin is still way up from the bottom of the list.

The states that have a lower ratio of applicants to population are in this order: Alaska, 3.05 (the lowest in the United States); Hawaii, 3.79; Maine, 3.79; New Mexico, 4.31; Nevada, 4.74; New Hampshire, 5.12. (I would pause here to point out that none of these states has a medical school.) Missouri, 5.70 (and they have three medical schools); North Carolina, 6.24 (with three medical schools); Delaware 6.57 (with no medical school), and Wisconsin, 6.61.

This means to me that perhaps Missouri, North Carolina and Wisconsin aren't doing the kind of recruiting they should be doing. When we realize that a state like Nebraska has 11.1 applicants per 100,000 population, something is happening in that State which is inducing young people to consider medicine as a career.

I believe this is a serious matter which is of great interest, of course, to the medical schools themselves here in Wisconsin, but certainly it should be to our own Wisconsin medical profession because you people are in a key position to induce young people to consider medicine as a career.

I want to congratulate Michigan and the Commission on Hospital Relations and Medical Education of our State Society for taking a most vigorous approach to this subject. I encourage all of you to cooperate in the efforts being conducted by this Commission.

What has Marquette University School of Medicine done about this during the past year? Our own Student AMA Chapter has been one of the leaders in the United States in developing programs to induce high school students and college students to consider medicine as a career. They have done this through annual Career Guidance Day. This last Career Guidance Day was held last Saturday. Over 400 high school and college students from the area of out-Milwaukee and as far away as Antigo and Peoria, Illinois, visited the Medical School and saw presentations designed for them, to interest them and to acquaint them with the study of medicine, dentistry, medical technology, physical therapy and dental hygiene and nursing. This is perhaps the most successful venture the Student AMA at Marquette has conducted to date, and it is one way in which we are attempting to influence the young people in this important activity.

In addition to this, we are opening our School periodically to visits by students in the 7th and 8th grades. A number of schools in the Milwaukee area have visited the Medical School and have taken a short, quick tour through the place and have been told something about the health professions.

I ask you, therefore, out at the grass roots and around the State, to encourage all of this sort of activity because I believe this is most important not only for our future as a medical profession but certainly for the health of our people.

One thing that I can specifically recommend to the State Medical Society as an organization is that they should establish, if possible, a prize to be given at the various Science Fairs that are conducted throughout the State. The Dental Society is doing this, the Cancer Society, the Engineering Society, and I would like to see the State Medical Society give one of the fine prizes given for a biology type of exhibit in the various Science Fairs.

Now I would like to say a few words about the student body in the Marquette University School of Medicine. The number of students in our School entering each year remains in the neighborhood of 100. This is the capacity for our facilities as they exist today. About half of these students year after year come from the State of Wisconsin. About 30 to 35 per cent of them are residents of Milwaukee County.

The rest of our student body is coming from throughout the United States, with heavy concentrations from Ohio in recent years, and from the neighboring States of Michigan, Minnesota and Iowa, and with a considerably increased number coming from Illinois. We are therefore a Midwest medical school primarily, and we hope to be able to continue to be of great service to the population in this Midwest territory.

Now I would like to say a few words in conclusion about what our goals are in terms of developing Marquette University School of Medicine within the next decade or two. We believe we here in Milwaukee have the opportunity, as in immediate times before us, to develop a great medical center in this

L. H. LOKVAM, M.D., DONALD WILLSON, M.D., C. J. PICARD, M.D.

community and to develop it around the Milwaukee County institutions which, as most of you know, are among the finest in the United States.

Beautiful land which seems to have been destined by time to be used for health purposes exclusively is available, and we hope to be able to have built there a relocated veterans' facility which is now very definitely in the immediate future. We hope to have improved County facilities. We hope to have a private hospital type facility there. We also hope to have a relocation eventually of basic science departments of the Medical School and other related facilities.

This is our long-term goal. We feel it is a possibility. The Medical School can't do this itself because it is just one part in the development of such a major type of community medical center.

We feel that if such a program as this is developed, we will do a great deal to meet the ever-increasing shortage of physicians. We must expand the number of men entering the profession every year. We cannot rely forever on the importation of graduates of foreign medical schools to fill the ranks of the medical profession in the United States. Not that I have anything against this, but it seems to me we have an obligation to train more of our own people.

We must develop programs to fill in the great needs of our nation in medical research, because unless we do this American medicine and American health science, which now leads the world, I believe will very quickly be surpassed by activities that stem from behind the Iron Curtain.

We have a leadership in this field now in the United States; it is up to us as a nation to do all we can to foster it. Therefore, I encourage you not only to support the medical schools directly out-of-pocket, as you have done so generously—and at this point I want to thank each and every one of you for the contributions you are making through the AMEF, which is of great help to us. Actually, the money is used to shore up deficits that pop up here and there in our school; in fact, we are reaching a point where we are almost relying on this for our actual financing. This is a serious situation for a medical school to get into, but I see no other way out.

We want to thank you for this, and we want to encourage you as physicians to continue this type of support. We also want to encourage you as members of the great American community to do all that you can to first stimulate interest among our young people in medicine and the health sciences and the health professions as a career, and secondly to support through legislation all of the efforts which are necessary to continue to keep American medicine and American health science and the health professions at the top in the world.

REMARKS OF DEAN OF UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

Dr. John Z. Bowers (Madison): It is always a pleasure and a privilege to be invited to appear before you and to address you. I will be less than candid if I do not start off by trying to make some comments on one thing that you have been reading about a great deal, and that concerns the appointment of a new Chairman of our Department of Surgery.

There have been honest differences of opinion among members of the faculty in regard to the desirability of appointing a member of the faculty as against the desirability of appointing an individual from outside of the school. Major feelings about appointing someone from outside were based upon the feeling of many faculty members that there was a need for revitalization of the surgery program, which I know many share around the State.

The feeling that there should be a member of the faculty appointed was based upon the proved ability of some of our faculty members, concerns about too many appointments from outside, concerns about whether or not the faculty had the opportunity to progress and grow in the school as was desirable.

I think it was very unfortunate that our differences of opinion, which really are basically healthy differences, have been drawn into such a public controversy and have been kicked around as a political issue and have been distorted in many newspaper accounts. There has not been at any time, to my knowledge, any effort by anyone to abrogate the rules and regulations of the University. I believe if we get out of the newspapers (as I hope we have now) we can settle our problems in a way that will continue to bring credit to the State of Wisconsin in relation to the University of Wisconsin Medical School.

Next, I would like to express my appreciation to Doctor Heidner for the contribution from the American Medical Education Foundation, and in so doing express my appreciation to all of you for the support of physicians in the State of Wisconsin.

We have used this money for a variety of purposes. One of the things it helped us to do was to open a program in heart surgery. We are now doing three open heart cases a week and estimates indicate that such operations pro rate out to a cost of about $10,000 to $12,000 per operation. If one looks at the number of people involved, the facilities, the equipment, the amount of blood and a variety of other things, without the money from the American Medical Education Foundation this would not have been possible.

We have also used this money to establish a program to teach our school the use of radioactive elements in medicine. We have used it to teach students about physical medicine. We have used it in other areas. It is exceedingly valuable money.

Two weeks ago today I attended a meeting in Washington with the Board of Trustees of the American Medical Association, the Council on Medical Education of which I am privileged to be a member, and representative university presidents. There was general agreement that one of the quickest ways by which medicine may become a federally controlled program would be if our medical schools could not continue to turn out a completely adequate supply of physicians for the people of this country.

It is anticipated that the need will grow steadily. You might be interested to know that today there are plans under way for opening about ten to

twelve new medical schools in the next ten years. These range from Brown University in Rhode Island to the University of New Mexico; the University of Arizona; a new medical school in Southern California; a new medical school in Hartford, Connecticut; discussions on a new medical school in Toledo, Ohio.

Three weeks from now I expect to visit Idaho as a consultant because Idaho, Nevada, Wyoming and Montana are considering opening a regional medical school.

One concern we have is whether or not we will find students. We are well qualified to fill all these new medical schools, and I am certain that the support of the medical school is vital in this issue.

I may have commented before that I am sure we are not attracting young men and young women into medicine today as we did in the past, and I think one factor is a negative attitude on the part of the medical profession about the future practice of medicine. I am sure we all have apprehensions. I have.

The greatest apprehension I have is that we will not turn out an adequate supply of physicians, because physicians themselves are not sufficiently encouraging young men and young women. So, let me urge you to support us.

I would like to comment briefly on our hospital, because in past discussions with you I have expressed concern about an adequate supply of teaching material, and I am happy to be able to report that today our hospital census is way up, and I am sure that no small part of this is attributable to the interest and support of physicians in Wisconsin who realize that if we are going to run a medical school we have to have patients.

Our census on a number of occasions has been well over 90 per cent. We think we are out of the woods as far as the volume of teaching material at the Wisconsin General Hospital is concerned.

Our only concern is for variety. We need more ambulatory patients. We need more acute material. In an effort to attract a greater flow of this kind of material we will open, some time in the next two or three months, a rooming-in facility for patients who do not need admission to the hospital but who do need a place where they can sleep while they are being studied.

This will be opened on the first two floors of the nurses' dormitory, since the nurses are now in our general University dormitory program. It will be designed primarily for State welfare patients. I wish you would pass along the word that we do have a new program whereby State patients will not have to be admitted to the hospital but can come in through a rooming-in facility.

Also, I would like to report that we have an active program running with an artificial kidney. In the last month we have had three patients whose lives have been saved because of this, and we feel it is a good program.

Doctor Hirschboeck commented on the distribution of their students. We are heartened, too, by the fact that student applications at Wisconsin are up. We had about 350 applications this year in contrast to about 250 last year. We have selected a class of 100 well-qualified students, of whom 87 are from Wisconsin and 13 are nonresident students. Our policy is that we accept all well-qualified students and then we fill the class with students from outstate. This year the students who are nonresidents come from states all across the country, ranging from New York to California.

I also would like to report that one of the crucial factors, I think, in maintaining an adequate supply of physicians in Wisconsin, is the need for us to have attractive intern and resident programs which will help to keep our medical school graduates in the State. Each year I am distressed by the fact that so many of our graduates head for California, Oregon and Washington, never to return. They do this for internships. I think we really need to make a concerted effort by the Medical Society, the hospitals and the medical schools to see what can be done to improve our intern programs.

It was my privilege to meet with representatives of the Milwaukee County Medical Society and Council on Medical Education of the AMA during the past winter to talk about this, and I am very pleased that the State Medical Society will hold a conference shortly on how to run intern programs. I am sure Doctor Hirschboeck shares with me (in fact, I know he does) the very deep feeling that we should do everything we can to improve our internships.

Just to clear the record, let me say that medical schools can no longer assign graduates to internships. Second, Wisconsin (and I am sure this is true of Marquette) is very positive in encouraging our graduates to intern in Wisconsin. Third, a very important factor in the decision of the student as to where he will intern is how a hospital does on the national intern-matching program, and on that program our Wisconsin hospitals have done very poorly.

So, I think we ought to open up the books and take a look at our problem and see what can be done to improve it.

A ROUNDTABLE LUNCHEON MEETING

REMARKS OF NEW PRESIDENT-ELECT

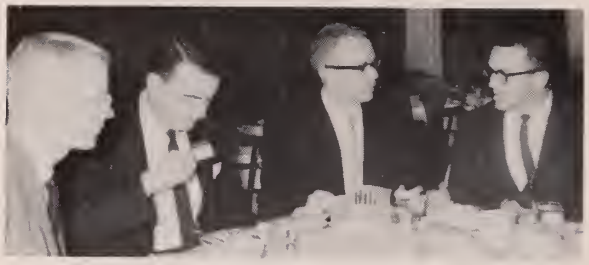
Dr. Nels A. Hill (Madison): I suppose anyone who accepts the Presidency of the State Medical Society does so with fear and trembling on the one hand, and with cognizance of the honor on the other. So it is with me.

The fear that the job is too big for one person awes me. These are fearful times, with threats to our way of life from all sides, with new worlds only a moon or Mars away, with outer space a reality. All of this is accompanied by an expanding scientific literature that a busy physician is pressed to study and understand.

However, knowledge dispels fear. We must avail ourselves of every means to increase our medical education. There are now many—attendance at meetings, medical journals, tapes, and the new newspaper-type periodicals.

The honor you have conferred on me is great, and is truly appreciated. For years the economic aspects of medicine have interested me. Our best approach to these problems is through "organized medicine" or the American Medical Association. You are the American Medical Association, and as you sit in this House you are aware of the working of a democratic form of government.

As with our Federal Government, most of the business is tracted in committees and by the Council throughout the year. Your action here approves or



ANOTHER ROUNDTABLE LUNCHEON SESSION

condemns. So, who is this ogre, this much-caricatured AMA? It is you; it is I. Since I do not know a single doctor in this State who is not devoted to his patients, I resent the image in which the physician is portrayed currently.

To change this, every one of us must be a better member of our county society. We should participate in community affairs and be informed on current legislation as related to medicine.

To be a good President I shall need help from my friends and colleagues in Dane County and the State, and especially from the Divine Physician.

Dear God, since every good deed and perfect gift must come from Thee, I pray, give skill to my hand, clear vision to my mind, and sympathy to my heart. Give me strength to lift at least a part of the burden of my suffering fellowman, and a true realization of the privilege that is mine. Amen.

ADJOURNMENT *SINE DIE*

The House of Delegates adjourned *sine die* at 10:30 a.m., May 3, 1961.

Attendance at House of Delegates

May 1, 2, and 3, 1961

SOCIETY:	Sessions 1	2	3
Ashland-Bayfield-Iron—			
J. M. Jauquet, Ashland	x	x	x
J. E. Kreher, Ashland	o	o	o
Barron-Washburn-Sawyer-Burnett—			
C. J. Strang, Barron	x	x	x
R. E. Lund, Cumberland	o	o	o
Brown—			
R. M. Waldkirch, De Pere	x	x	x
J. L. Ford, Green Bay	x	x	x
George Nadeau, Jr., Green Bay	x	x	x
J. E. Dettmann, Green Bay	x	x	o
Calumet—			
E. W. Humke, Chilton	x	x	x
A. C. Engel, New Holstein	o	o	o
Chippewa—			
A. W. Asplund, Bloomer	x	x	x
J. J. Sazama, Chippewa Falls	o	o	o
Clark—			
M. V. Overman, Neillsville	x	x	x
R. L. Hansen, Colby	o	o	o
Columbia-Marquette-Adams—			
R. T. Cooney, Portage	x	x	x
R. R. Rueckert, Portage	x	x	x
Crawford—			
T. F. Farrell, Prairie du Chien	o	x	x
W. A. Sannes, Soldiers Grove	o	o	o
Dane—			
W. T. Russell, Sun Prairie	x	x	x
V. W. Nordholm, Stoughton	o	o	o
R. S. Gearhart, Madison	x	x	x
R. L. Beilman, Madison	x	x	x
H. M. Suckle, Madison	x	x	x
C. W. Stoops, Madison	o	x	x
R. N. Allin, Madison	x	x	x
A. J. Richtsmeier, Madison	o	x	o
P. B. Golden, Madison	x	x	x
A. P. Schoenenberger, Madison	x	x	x
N. M. Clausen, Madison	x	x	x
R. P. Sinaiko, Madison	x	o	o
L. E. Holmgren, Madison	x	x	x
R. A. Straughn, Madison	o	x	x
T. J. Nereim, Madison	x	x	x
K. L. Siebecker, Madison	x	o	x
Dodge—			
L. W. Schrank, Waupun	x	x	x
H. G. Bayley, Jr., Beaver Dam	x	x	o
Door-Kewaunee—			
W. G. Sheets, Sturgeon Bay	x	x	x
D. E. Dorchester, Sturgeon Bay	x	x	x
Douglas—			
C. J. Picard, Superior	x	x	x
R. P. Fruehauf, Superior	o	o	o
Eau Claire-Dunn-Pepin—			
D. R. Griffith, Eau Claire	x	x	x
A. A. Drescher, Menomonie	o	x	o
I. L. Blose, Durand	x	x	x
W. R. Manz, Eau Claire	x	o	o
Fond du Lac—			
D. J. Twohig, Jr., Fond du Lac	x	x	x
W. E. Myers, Fond du Lac	x	x	x
Forest—			
E. F. Castaldo, Laona	o	o	o
B. S. Rathert, Cradon	o	o	o
Grant—			
H. W. Carey, Lancaster	x	x	x
C. L. Steidinger, Platteville	o	o	o
Green—			
R. G. Zach, Monroe	x	x	x
W. J. Staab	x	x	o
Green Lake-Waushara—			
H. C. Koch, Berlin	x	x	o
L. J. Seward, Berlin	o	o	o
Iowa—			
W. D. Hamlin, Mineral Point	x	x	o
J. B. Shack, Highland	o	o	o
Jefferson—			
H. G. Mallow, Fort Atkinson	o	x	x
R. W. Quandt, Jefferson	x	o	o

First name is delegate, indented name is alternate.
x—present. o—absent.

	Sessions 1	2	3
Juneau—			
Jack Strong, Mauston	x	x	o
M. S. Tverberg, Mauston	o	o	o
Kenosha—			
R. W. Ashley, Kenosha	x	x	x
G. C. Schulte, Kenosha	o	o	o
La Crosse—			
J. P. McCann, La Crosse	x	x	x
K. P. Ruppenthal, Bangor	o	o	o
R. E. McMahon, La Crosse	x	x	x
R. W. Ramlow, La Crosse	o	o	o
Lafayette—			
L. L. Olson, Darlington	x	o	o
R. E. Hunter, Argyle	o	o	x
Langlade—			
B. W. Beattie, Antigo	o	x	x
W. P. Curran, Antigo	x	x	x
Lincoln—			
J. F. Bigalow, Merrill	x	x	x
K. A. Morris, Merrill	o	o	o
Manitowoc—			
W. E. Acheson, Valders	o	o	o
R. G. Yost, Manitowoc	o	x	o
Marathon—			
E. P. Ludwig, Wausau	o	x	x
D. M. Green, Wausau	x	x	x
Marinette-Florence—			
C. E. Koepp, Marinette	x	x	x
W. J. Boren, Jr., Marinette	o	o	o
Milwaukee—			
E. G. Collins, West Allis	x	x	x
R. H. Frederick, West Allis	o	o	o
G. E. Collentine, Jr., Milwaukee	x	x	o
R. A. Nimz, Milwaukee	o	o	o
S. W. Hollenbeck, Milwaukee	o	x	o
O. G. Fais, Milwaukee	o	o	o
Edgar End, Wauwatosa	x	x	x
D. J. Carlson, Milwaukee	o	o	o
L. R. Weinshel, Milwaukee	x	x	x
W. S. Polacheck, Milwaukee	o	o	o
S. L. Chojnacki, Milwaukee	x	x	o
S. E. Zawodny, Milwaukee	x	x	o
G. W. Hilliard, Jr., Milwaukee	x	x	x
W. H. Frackelton, Milwaukee	o	o	o
Norbert Enzer, Milwaukee	x	o	x
F. J. Millen, Milwaukee	o	o	o
F. A. Ross, Milwaukee	x	x	o
N. G. Bauch, Milwaukee	o	x	o
W. G. Houghton, Milwaukee	x	x	x
G. V. Murphy, South Milwaukee	x	x	o
W. J. Conen, Milwaukee	x	x	o
A. E. Roethke, Milwaukee	o	o	o
V. L. Baker, Milwaukee	o	x	x
R. T. Sproule, Milwaukee	x	o	o
H. M. Klopf, Milwaukee	x	x	x
B. J. Peters, Milwaukee	o	x	o
J. W. Fons, Milwaukee	x	x	x
W. L. Coffey, Milwaukee	o	o	o
C. M. Schroeder, Milwaukee	x	x	x
K. E. Sauter, Milwaukee	o	x	x
H. F. Twelmeyer, Wauwatosa	x	x	x
D. W. Calvy, Wauwatosa	o	o	o
A. J. Sanfelippo, Milwaukee	x	x	x
J. J. Barrock, Milwaukee	o	x	o
F. E. Drew, Milwaukee	x	x	x
R. E. Callan, Milwaukee	x	x	x
H. J. Lee, Milwaukee	x	x	o
R. S. Haukohl, Milwaukee	x	o	x
R. F. Purtell, Milwaukee	o	o	o
E. D. Wilkinson, West Allis	x	x	x
J. F. Cary, Milwaukee	x	x	o
E. J. Schmidt, Wauwatosa	x	x	o
D. M. Willson, Milwaukee	x	x	x
J. R. Evrard, Milwaukee	x	x	x
P. E. Oberbreckling, Milwaukee	x	x	x
K. A. Liefert, Wauwatosa	o	o	o
D. M. Ruch, Milwaukee	x	x	o
R. H. Lillie, Milwaukee	o	o	o

	Sessions 1	2	3
Monroe—			
R. G. Konicek, Tomah	x	x	o
D. C. Beebe, Sparta	o	o	o
Oconto—			
H. A. Aageson, Oconto	o	o	o
G. R. Sandgren, Suring	o	o	o
Oneida-Vilas—			
W. K. Simmons, Rhinelander	o	o	o
L. L. Jacobson, Eagle River	x	x	x
Outagamie—			
G. A. Behnke, Kaukauna	x	x	x
W. H. Hale, Appleton	o	o	o
J. H. Russell, Appleton	x	x	x
J. G. Bergwall, Hortonville	o	o	o
Ozaukee—			
J. F. Walsh, Port Washington	x	x	o
R. H. Dorr, Belgium	x	x	x
Pierce-St. Croix—			
P. H. Gutzler, River Falls	x	x	x
C. A. Olson, Baldwin	x	x	x
Polk—			
L. O. Simenstad, Osceola	x	x	x
R. M. Moore, Frederic	x	x	x
Portage—			
F. E. Gehin, Stevens Point	x	x	x
W. A. Gramowski, Stevens Point	o	o	o
Price-Taylor—			
L. E. Nystrum, Medford	x	x	x
J. D. Leahy, Park Falls	o	o	o
Racine—			
G. L. Rothenmaier, Racine	x	x	x
W. F. Henken, Racine	o	o	o
L. E. Fazen, Jr., Racine	o	x	x
V. J. Burch, Racine	x	o	o
Richland—			
D. J. Taft, Richland Center	o	o	x
R. E. Housner, Richland Center	x	x	o
Rock—			
D. M. Clark, Beloit	x	x	x
A. H. Twyman, Beloit	o	o	o
M. D. Davis, Milton	x	x	x
M. F. Purdy, Janesville	o	o	o
Rusk—			
H. F. Pagel, Ladysmith	x	o	x
M. L. Whalen, Bruce	o	o	o
Sauk—			
C. R. Pearson, Baraboo	x	x	x
E. V. Stadel, Reedsburg	o	o	o
Shawano—			
D. A. Jeffries, Shawano	x	x	x
H. F. Laufenburg, Shawano	o	o	o
Sheboygan—			
J. E Martineau, Elkhart Lake	x	x	o
J. W. McRoberts, Sheboygan	o	o	x
Trempealeau-Jackson-Buffalo—			
E. P. Rohde, Galesville	x	x	x
W. E. Wright, Mondovi	x	x	x
Vernon—			
L. F. Gulbransen, Viroqua	x	x	x
P. T. Bland, Westby	o	o	o
Walworth—			
J. E. Martin, Jr., Delavan	x	x	x
R. S. Galgano, Delavan	x	o	o
Washington—			
W. A. Nielsen, West Bend	x	x	x
W. E. Scheunemann, West Bend	o	o	o

	Sessions 1	2	3
Waukesha—			
J. F. Wilkinson, Oconomowoc	x	x	x
A. F. Rogers, Oconomowoc	o	o	o
J. A. Bartos, Waukesha	o	x	x
J. V. Bolger, Waukesha	x	o	o
Waupaca—			
O. E. Larson, Clintonville	x	x	o
W. R. McInnis, Marion	o	o	o
Winnebago—			
E. A. Strakosch, Oshkosh	x	x	x
S. J. Graiewski, Oshkosh	x	x	o
G. P. Schwei, Menasha	x	x	x
G. H. Hardie, Neenah	o	o	o
Wood—			
E. C. Glenn, Wisconsin Rapids	x	x	x
W. B. Larkin, Marshfield	x	x	o
SECTION:			
General Practice—			
R. R. Richards, Eau Claire	x	o	x
J. A. Kelble, Milwaukee	o	x	o
Internal Medicine—			
L. J. Kurten, Racine	x	x	x
R. L. Gilbert, La Crosse	o	o	o
Neurology—			
Ervin Teplin, Milwaukee	o	o	o
Obstetrics-Gynecology—			
D. J. Werner, Milwaukee	x	x	o
J. J. Boersma, Green Bay	o	o	o
Ophthalmology-Otolaryngology—			
R. T. Rank, Milwaukee	x	o	o
R. T. Schmidt, Green Bay	o	x	x
Orthopedics—			
P. K. Odland, Janesville	x	x	o
M. W. Nelson, Racine	o	o	o
Pathology—			
J. L. Teresi, Brookfield	x	x	o
R. W. Steube, Fond du Lac	o	o	o
Pediatrics—			
J. P. Conway, Milwaukee	x	x	o
K. J. Winters, Wauwatosa	o	o	o
Public Health—			
J. A. Van Susteren, Sparta	x	x	x
J. C. Antonmattei, Milwaukee	o	o	o
Radiology—			
I. I. Cowan, Milwaukee	x	x	o
L. E. Jones, Racine	o	o	o
Surgery—			
J. T. Mendenhall, Madison	x	x	o
R. B. Larsen, Wausau	o	o	o
Urology—			
J. W. Sargent, Milwaukee	x	x	x
R. S. Irwin, Milwaukee	o	o	o

Minutes of Council Meeting

Milwaukee, April 30, 1961

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 2:00 p.m. on Sunday, April 30, 1961, at the Hotel Schroeder in Milwaukee.

All voting members of the Council were present, Doctors Hill, Conway, Kilkenny, and Hildebrand for the afternoon session only. Others present were President Sorenson; President-elect Lokvam; Treasurer Weston for the evening session; Speaker Nordby; Doctors Simenstad, Bernhart, Quisling, Galasinski, delegates to the American Medical Association; Doctors Collentine and Sullivan, alternate delegates; Doctor Heidner, councilor emeritus; Doctor R. M. Waldkirch, reference committee chairman; Messrs. Crownhart, Thayer, Ragatz, Reynolds, Hansen, Sprain, Toser, Murphy, Gill, White; Mrs. Anderson, Misses Rendall and Pyre.

2. Approval of Minutes of Annual Meeting of Council

On motion of Doctors Curran–James, carried, minutes of the February 25–26, 1961, annual meeting were approved.

3. Health Manpower Study

The Executive Committee had reported its review of a proposed study of Wisconsin manpower in the health sciences, and that Dean Bowers and Doctor Ira Baldwin, Secretary, Coordinating Committee on Higher Education of the University of Wisconsin, had been invited to meet with the Council to discuss the matter.

Since they were unable to be present, on motion of Doctors Egan–Hill, carried, the subject was referred to the Planning Committee for detailed follow-up and report to the Council as time goes along.

4. Personal Service Corporation

The Council discussed the proposed bill recently distributed to the membership to permit establishment of deferred compensation retirement plans.

On motion of Doctors Ekblad–Schulz, carried, the Council recorded its approval of the Personal Service Corporation bill.

5. Kerr–Mills Implementation

The Council discussed at considerable length the development of the bill to implement the Kerr–Mills Act in Wisconsin which had likewise been distributed to the membership.

On motion of Doctors Dessloch–Bell, carried, the Council recommended the bill for approval by the House of Delegates with an amendment specifically stating a guarantee of free choice of physician for its beneficiaries.

6. Hospital Achievement Awards

On motion of Doctors Egan–Hildebrand, carried, the Council approved granting the hospital achievement awards to those hospitals nominated by the Commission on Hospital Relations and Medical Education: St. Joseph's Memorial Hospital, Hillsboro, and St. Luke's Memorial Hospital, Racine.

7. Report on Washington Trip

On motion of Doctors Ekblad–Schulz, carried, the Council transmitted to the House of Delegates the report of the special committee of the Council which went to Washington in March to survey the socio-political-economic scene.

It also heard supplementary remarks from members of the committee present at the Council meeting.

8. Crash Injury Research Program

On motion of Doctors Kilkenny–Blanchard, carried, the Council approved a recommendation of the Division on Safe Transportation, Commission on State Departments, that the Society give its official approval to an automotive crash injury research program to be conducted by Cornell University through the Motor Vehicle Department.

9. Commission on State Departments Elections

a. General Chairman

The renomination of T. W. Tormey, Jr., M.D., was offered by Chairman Fox and President Sorenson, and on motion, there being no other nomination, was voted unanimously.

b. Division Chairmen

The nomination by Doctor Kilkenny of John Evrard, M.D., of Milwaukee, as chairman of the Division on Maternal and Child Welfare, was approved by the Council.

By separate motion duly made, seconded and carried, all other division chairmen were re-elected, as follows:

- A. M. Hutter, M.D., Fond du Lac, Division on Aging
- H. A. Anderson, M.D., Stevens Point, Division on Chest Diseases
- J. W. Nellen, M.D., Green Bay, Division on Handicapped Children
- E. D. Schwade, M.D., Milwaukee, Division on Nervous and Mental Diseases
- H. W. Carey, M.D., Lancaster, Division on Public Assistance
- Ray Piaskoski, M.D., Milwaukee, Division on Rehabilitation
- Dayton Hinke, M.D., Richland Center, Division on Safe Transportation
- L. M. Simonson, M.D., Sheboygan, Division on School Health
- Meyer S. Fox, M.D., Milwaukee, Division on Visual and Hearing Defects

10. Appointments to State Board of Medical Examiners

By statute, the State Medical Society has the privilege of recommending nominees for appointment by the Governor to the State Board of Medical Examiners.

On motion of Doctors Houghton–Hildebrand, carried, the Council approved the slate of nominees suggested by the Executive Committee for the three doctors of medicine whose terms expire in 1961.

11. Report of Executive Committee

a. The Case of Terrence Donovan (See editorial, "Social Dilemma," March, 1961, *Wisconsin Medical Journal*)

On motion of Doctors Bell–Hill, carried, the Council approved the recommendation of the Executive Committee that the general problem exemplified in this case be referred to the Commission on State Departments with the suggestion that a joint conference be arranged with representatives of the State Bar of Wisconsin to consider institution of proper mechanisms for the release from custody of those adjudged insane.

b. Status of return to fall meeting

Mr. Ragatz reported the Executive Committee recommendation that the Scientific Committee of the Council together with the Commission on Scientific Medicine meet with representatives of the Wisconsin Academy of General Practice to discuss the possibilities of a combined fall meeting or an exchange of dates, since this appeared to be the only possibility in the foreseeable future for the State Medical Society to secure desirable meeting dates in the fall.

Doctor Bell also suggested that consideration be given to separating the House of Delegates meeting from the scientific sessions and holding it in the fall in various areas of the state.

On motion of Doctors Bell–Conway, carried, this matter was referred to the appropriate Council committee for study and recommendation.

c. Proposed meeting with other groups

The Secretary reported a proposal to President Sorenson and himself that meetings periodically be arranged between officials of the State Medical Society and certain other groups.

The Executive Committee referred the matter to the Council and was generally agreed that such arrangements be made. The recommendation was approved by motion of Doctors Conway–Curran, carried.

Further report of Executive Committee, April 29 meeting, distributed to the Council:

a. Workshop on Home Care Services

On motion of Doctor Houghton, seconded and carried, the Council approved the committee recommendation that the Commission on Medical Care Plans select two of its members to represent the Society at the AMA National Workshop on Home Care Services, May 24–26, 1961, and that the staff also be represented.

b. Resolution on relationships between medicine and optometry

The committee reported a resolution from Tennessee calling for a study by the AMA of the relationships between medicine and optometry.

No action was taken by the Council, it being left to the discretion of the Wisconsin delegation to decide its position at the time of the meeting.

c. Section delegates

The committee recommended approval of the section delegates' request that meetings be held with a committee of the section delegates and officers for the purpose of clarifying their organization and functions under the bylaws, and to assist the sections in more active participation in Society affairs.

On motion of Doctors Houghton–Curran, carried, the recommendation was approved.

d. House of Delegates voting procedures

The committee proposed that the procedures established for the qualification of voting delegates be reaffirmed to the House. No action.

e. November Council meeting

The Executive Committee reported that November 11–12 had been selected as the dates on which to attempt to arrange the Council meeting at AMA headquarters in Chicago, as earlier approved.

f. Resolution on AMA dues increase

It recommended that a Nebraska resolution relating to the use of increased AMA dues for PR purposes be referred to the Wisconsin delegates to the AMA. No action.

g. Rule of Order

The committee recommended that it be a standing rule of the Council that when or if it meets in joint session with other bodies, the Council go into executive session for discussion and vote on any matters requiring action in such meetings.

On motion of Doctors Curran–Blanchard, carried, the rule was adopted.

h. Standing Committee Appointments

The committee reported that by custom the president-elect reviewed with it his standing committee appointments.

i. Non-medical Trustees of the Foundation

On motion of Doctors Dessloch–Schulz, carried, the Council approved the election of three non-medical trustees nominated by the Executive Committee: Mr. Warren E. Clark, Milwaukee; Mr. E. E. Bryant, Stoughton; and Mr. Robert B. Murphy, Madison.

j. Annual Dinner Program

The committee reported that henceforth arrangements for the annual dinner program will be centered in the Executive Committee.

12. Immediate Past President on Executive Committee

Doctor Hildebrand moved that steps be taken to have the immediate past president ex officio a member of the Executive Committee. Motion seconded by Doctor Kief and carried.

The Council then recessed after a rising tribute to Doctor Sorenson for his service as President.

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13. Report of Executive Committee Continued

k. Resolutions proposed by Executive Committee for House action

(1) On motion of Doctors Van Hecke–Egan, carried, a resolution was tabled which requested county societies, councilor districts, specialty societies and others to refrain from scheduling scientific or organizational meetings during a period of time in which efforts should be concentrated on the annual meeting of the Society.

A motion of Doctors Van Hecke–Fons that these various groups be written to this effect, rather than by formal resolution, was approved.

(2) On motion of Doctors Mason–Egan, carried, a resolution reaffirming opposition to Forand-type legislation was approved for presentation to the House of Delegates.

l. Medicare

The Executive Committee recommended that the Society's contract with Medicare for 1961 be signed under protest and the AMA be asked to establish a national policy with regard to reimbursement for polio immunizations of Medicare recipients. Discussion followed.

A motion by Doctors Egan–Mason that in light of the information presented by the Secretary to the Council, the matter be handled in the best manner possible by the Society executives, was approved.

14. Report of Finance Committee

a. Investment Counsel

Doctor Dessloch reported that the Finance Committee recommended the acquisition of an investment counseling firm to broaden the investment aspects of the State Medical Society pension fund and diversify the program to include common stocks, with limitations up to 40% of surplus to be achieved over a period of time; also to review WPS investments and advise the best in governments or in solid investments.

Doctor Egan wanted to point out to the Council the need for the advice of specialists even in the investment of governments only, and that the object of an investment program should be maintenance of capital with the best rate at least possible risk.

On motion of Doctors Dessloch–Egan, carried, the Council retained the firm of Scudder, Stevens & Clark, Inc., on a yearly basis, to counsel on all investment needs.

On further motion of Doctors Bell–Curran, carried, the Society treasurers, with administration, were designated implementing agents.

b. Financial Report on all Society activities

The Finance Committee reviewed the summary report prepared by the certified public accountants and as requested by the 1960 House of Delegates covering all Society activities.

On motion of Doctors Bell–Schulz, carried, the report was forwarded to the House of Delegates.

c. Executive Salaries

On motion of Doctors Dessloch–Bell, carried, the present salary schedule is to be maintained until reviewed at the next regular Council meeting.

15. Supplementary Report of Division on Handicapped Children

Mr. Ragatz explained that the House of Delegates in May 1960 had requested revision of the Bicillin program operated through the State Bureau for Handicapped Children to eliminate mandatory confirmation by a specialist or heart clinic of the physician's original diagnosis of rheumatic fever.

On motion of Doctors Egan–Curran, carried, the supplementary report of the Division outlining the revised program based on the Jones criteria which had been worked out with the state bureau was approved for forwarding to the House.

16. Report of Commission on Public Policy

a. Chiropody

Doctor Quisling reported current negotiations with representatives of the podiatry association as to their legislative proposals which were to be heard before an Assembly committee that week. Considerable discussion ensued. Doctor Quisling hoped that the Council would specify any areas of agreement, and he would attempt to arrange a period of time during which an acceptable statutory definition could be worked out with them.

The Council did not oppose the wish of the chiropodists to change their designation from chiropody to podiatry. Principal points of difference were on the extent of their use of anesthetics, use of narcotics, and the total definition of their practice. It was stated that they are now permitted the use of local anesthesia, and are applying it topically and by injection, but want the latter authorized by statute. On the use of codeine or other narcotics, Doctor Egan pointed out that there are a number of exempt narcotics and remedies other than codeine that can be used.

Doctors Fons and Dessloch spoke in support of medicine standing firmly that no area of medical practice be permitted limited licensees not fully qualified to practice it. They indicated that it was the duty of medicine to oppose anything inimical to the public health.

Doctor Curran moved that the Council give an expression to the Commission on Public Policy that in its contacts with the podiatrists they be allowed the use of local anesthesia in their work, but that they continue to be denied the privilege of prescribing narcotics. Motion seconded and carried, Doctor Dessloch voting in the negative.

On motion of Doctors Egan–Blanchard, carried, the Council approved a resolution to be forwarded by the Commission on Public Policy to the House of Delegates calling for a thorough review and study of chiropody by the AMA for the purpose of establishing agreement as to its definition, the scope and quality of its education, and uniformity as to its standards of practice.

b. Chiropractic

On motion of Doctors Curran–Blanchard, carried, the Council adopted a resolution relating to chiropractors in Wisconsin and approved its transmittal to the House by the Commission on Public Policy.

c. Home Care by Public Health Nurses

Doctor Quisling reported that the Commission had worked with the State Board of Health in removing some of the earlier objections to the Board's bill to provide for home care by public health nurses with charge to patients. However, he asked the Council if it still objected to the charging and collection of a fee for these services.

On motion of Doctor Curran, seconded and carried, the Council reaffirmed its opposition.

Mr. Crownhart paid tribute on behalf of the staff to Doctor Quisling on his retirement as chairman of the Commission on Public Policy, and the Council gave him a rising vote of thanks.

17. Resolution

Doctor Kief read a resolution which Doctor Hildebrand asked him to present to the Council for transmittal to the House, from some members of the sixth councilor district, requesting referral and study by a Council committee of the creation of an arbitration board from the legal and medical professions.

A motion by Doctors Kief–Blanchard that the resolution be transmitted to the House was amended by Doctors Egan–Schulz that it be referred to the Executive Committee of the Council. Chairman Fox ruled that the amendment to refer to a committee took precedence, and it was carried unanimously.

18. Further Committee Reports

On motion of Doctors Dessloch–Blanchard, carried, the report of the Council Committee on Health Economics of American Life (HEAL) was approved for submission to the House of Delegates.

The Council also received a copy of the report of the Commission on Public Relations and Communications, a standing committee which reports directly to the House.

19. Resolution

Doctor Houghton moved that the following resolution be transmitted by the Council to the House of Delegates, seconded by Doctor Curran and carried:

> *Resolved*, That the Council of the State Medical Society of Wisconsin recommend to this House of Delegates that each county medical society designate certain members of its local society to prepare and present to local groups in their own communities medicine's views and stands on state and national issues relating to medicine and health.

20. Adjournment

The Council adjourned at 10:00 p.m.

C. H. Crownhart
Secretary

Approved
James C. Fox, M.D.
Chairman

CHANGES IN MENTAL HEALTH PROGRAM

Milwaukee County Institutions, Milwaukee 13, Wisconsin

The Milwaukee County Institutions (Milwaukee 13, Wisconsin) announces several changes in its mental health program. The Hospital for Mental Diseases has been re-named the Milwaukee County Mental Health Center, North Division, and the Asylum's name has been changed to the Milwaukee County Mental Health Center, South Division. The adult psychiatric outpatient clinic, formerly a unit of the Hospital for Mental Diseases, has been established as a separate entity known as the Milwaukee County Psychiatry Clinic. The Milwaukee County Division of Mental Health is now as follows:

DIVISION OF MENTAL HEALTH—Charles W. Landis, M. D., Director
Milwaukee County Mental Health Center:
North Division—Chris J. Buscaglia, M.D., Medical Director
South Division—Rudolph J. Depner, M.D., Medical Director
Milwaukee County Psychiatry Clinic—George E. Currier, M.D., Director
Milwaukee County Guidance Clinic—Sara G. Geiger, M.D., Director

Minutes of Special Council Meeting

Madison, June 18, 1961

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 11:00 a.m. at Society headquarters in Madison. Councilors present were Doctors Nordby, J. H. Houghton, Dessloch, Blanchard, Kief, Fox, Bell, Mason, Frank, Egan, W. J. Houghton, and Willson. Officers and others: President Lokvam, Vice Speaker Carey, AMA Delegate Simenstad; Messrs. Crownhart, Toser, Murphy, Desmond, Gill, Tiffany, Koenig, Sprain, Reynolds, Mulady, Mrs. Anderson, Misses Moran and Pyre. Members of the Commission on Medical Care Plans, which had adjourned its quarterly meeting at 10:45, remained for the Council meeting.

2. Oath of Office and Announcements by Chairman

Chairman Fox welcomed the new councilors and administered the oath of office to Doctors W. J. Houghton, D. M. Willson, E. J. Nordby, councilors, and H. W. Carey, vice speaker.

He announced the appointment of Doctors W. J. Houghton and E. D. Sorenson, past president, to the Committee on Scientific Medicine; Doctors W. J. Egan and D. M. Willson to the Committee on Economic Medicine, Doctor Egan as its chairman and in that capacity as a member of the Executive Committee; Doctor E. J. Nordby to the Finance Committee to fill the unexpired term of Doctor Hill on that committee which runs until 1963. He reappointed Doctors James and Frank to the Finance Committee for terms expiring in 1964.

3. Special Order—Housing of Society Activities

As reported in the call for the special meeting and in a subsequent communication, very recent negotiations for renewal of the lease on rented office space were concluded in the virtual certainty that it would not be renewed after the period ending October 31, 1962. There were 42 employes housed in this space, with 98 in the Society building which was intended to house a maximum of 87. It was also reported that the Executive Committee had a week earlier discussed the several alternatives of: (1) renting other space; (2) purchasing a building; (3) constructing an addition. Its recommendation was that appropriate request be directed to the SMS Realty Corporation and that construction of an addition be undertaken as soon as possible for occupancy by November 1, 1962.

Before discussion by the Council, Mr. Crownhart presented slides showing the plot, exterior and floor plan of a building possibly available for purchase and adaptable for Society use. He also showed slides of tentative drawings of a three-story addition to the present building with the ground floor set into the hill to the west and two floors rising above it; a view of the floor elevations; and a drawing outlining property owned by the Society.

Mr. Murphy presented on slides a computation of refinancing for construction of an addition, assuming costs at a given figure and 1961 valuations of land and improvements. His calculations resulted in a measurable excess of the maximum first mortgage loan permitted WPS by statute over funds needed for construction under the above assumptions.

Question was raised as to whether the addition would have any impact on the dues structure, and in particular the third floor which is contemplated for meeting purposes initially. The Secretary on request stated that details on proposed use would be reported at a later meeting.

After discussion by the Council as to space needs for current use and future expansion, and viewing of the property and staked-out area, Doctor Willson moved that the Secretary be empowered to consult with the architects for the drawing of final plans and submission of bids, which are to be returned to the Council for final action, to design a building adjacent to the existing building of 12,000 foot capacity (two floors) with facilities to allow for the addition of a third floor at minimal expense. Motion seconded by Doctor Bell for purposes of discussion.

After further discussion, Doctors Willson–Bell agreed to revise the motion to allow for taking of bids on three alternative bases: two completed floors with facilities to allow for the addition of a third; two completed floors with the third roughed in; three completed floors. Motion carried.

Mr. Crownhart stated his understanding that the motion permitted discretion in the taking of various alternate bids. For example, if the third floor is not added at this time, an elevator shaft might be planned but no bid taken for installation of an elevator.

Doctors Kief–Blanchard asked that the information presented at the special meeting be duplicated and sent to the Council.

4. Adjournment

The meeting was adjourned at 2:45 p.m.

C. H. Crownhart
Secretary

Approved
James C. Fox, M.D.
Chairman

SPECIALISTS AND GENERAL PRACTITIONERS

Available through Placement Service

The Placement Service of the State Medical Society has registered with it a number of specialists in various fields as well as general practitioners. Contact the Placement Service by writing Box 1109, Madison, Wisconsin.

the Wisconsin Medical Journal

OCTOBER 1961

VOLUME 60
NUMBER 10

A Festschrift
dedicated to
William Davison Stovall, M.D.

THIS ISSUE of the Wisconsin Medical Journal is a unique departure from the usual format of the official publication of the State Medical Society. Not for many years has a regular issue been devoted to a special subject.

Your Editorial Board takes great pleasure in presenting this timely recognition of a great colleague, William D. Stovall, M.D., and his devoted efforts on behalf of public health and welfare, especially in the cause of cancer prevention and control.

For nearly 40 years Doctor Stovall has served the medical profession and the people of Wisconsin. These pages, written by a few of his students and close associates at the request of the editors, record the thanks of many in Wisconsin and across the nation who recognize his fine contributions to better health and longer, happier life.

Our appreciation goes to all those who have assisted in the preparation of this Journal, and particularly, to the Wisconsin Division, American Cancer Society, for its generous contribution in support of this issue.

And to Doctor Stovall, our sincere best wishes.

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Assistant Medical Editor

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M. C. F. LINDERT, M.D., Milwaukee

D. N. GOLDSTEIN, M.D., Kenosha
Editorial Director

W. D. Stovall

The Council Award

State Medical Society of Wisconsin
1940

The highest honor in the power of the State Medical Society of Wisconsin to bestow upon one of its members is The Council Award. It is granted but on occasion. It is granted only to such as have served with outstanding distinction the science of medicine, and their fellow physicians, and the public. In the ten years since The Council Award was established, fifteen awards have been made. Tonight we give another.

William Davison Stovall

a son of Mississippi of the fourth generation of physicians; distinguished as a bacteriologist and pathologist; a teacher whose example has been an inspiration to another generation of physicians; for a quarter of a century acting director and director of our State Laboratory of Hygiene; two years acting superintendent of the Wisconsin General Hospital; successively Secretary, Vice-President, President, and Trustee of the Dane County Medical Society; ten years chairman of the Committee on Cancer of the State Medical Society of Wisconsin, earlier chairman of its Committee on Health and Public Instruction, several terms a member of its House of Delegates and Speaker of that body in 1931; committee chairman of the American Public Health Association, and state chairman and director of the American Society for the Control of Cancer,—for your attainments in the field of science; for your public service in hygiene and preventive medicine as coordinator of physicians, public, and state in joint action that has brought new health records to our citizenry through the greatest of all public health forces —an alert army of capable physicians and an educated public; for your furtherance of the aims of your Society; and for your unswerving allegiance and devotion to the maintenance and building of the untrammeled general practitioner of medicine as the foundation of an unconquerable and inspired American medicine, we, your fellow members, give you this seal of our Society as a token of your achievement and of our esteem and affection.

TO DOCTOR STOVALL: a teacher

From GAYLORD A. NELSON, Madison
Governor, State of Wisconsin

It is an honor to contribute to the *Wisconsin Medical Journal's* commemoration of your service to the state.

It is indeed rare that a person is able to carry on three outstanding careers for almost half a century. Yet this is the record you have established since you came to Wisconsin in 1914.

The State Laboratory of Hygiene has grown from a minor operation to perhaps the farthest-reaching part of our public health services during your many years as director. Laboratory service has been extended to every doctor and every person in the state. Your contribution has been great in the progress which has reduced to obscurity some of the diseases which once were scourges.

As a teacher of doctors your record is equally long and fruitful. Your career has spanned revolutionary developments in clinical pathology, bacteriology, and public health; you have sought and discharged the responsibility for imparting the secrets of these sciences to thousands of medical students and doctors. You have had the distinction of training in the medical profession the sons and daughters of doctors you taught during their years in the medical school.

Your career as a member and chairman of the State Board of Public Welfare has been no less notable. Close by the State Laboratory of Hygiene, the Diagnostic Center stands on the University of Wisconsin campus as a monument to your work in this field since your appointment in 1942. I was very pleased to have the opportunity to reappoint you to another term as chairman just a few months ago. Improvements in recent years in all the state welfare institutions bear the stamp of your interest and ability.

To say that you have had three careers is an understatement, for your interests have led you into noteworthy contributions in many fields and activities which would require pages just to list.

Let it suffice to say that your service to medicine and to the welfare of Wisconsin citizens has been outstanding. I am sure the people of our state join me in thanking you for your years of service and in hoping that your activities on our behalf will continue for many years to come.

Gaylord Nelson

From OSCAR RENNEBOHM, Madison
Former Governor, State of Wisconsin

It was good news to read that you are continuing your work with the University.

During my service to the State of Wisconsin, both as Governor and as Regent of the University, it was my good fortune to work with you on many important projects of state and national concern. I always found that your ability and broad background training helped materially in clarifying the problems at hand and effecting their solution.

In the field of public welfare you have always given generously of your wealth of understanding and experience. Your devotion to your work and your willingness to help whenever and wherever needed have resulted in countless benefits to the people of our state and have earned for you their lasting gratitude. We are fortunate to have such a valued public servant.

I hope you will enjoy good health for many years to come and will be able to continue your fine work.

Oscar Rennebohm

From WALTER J. KOHLER, Kohler
Former Governor, State of Wisconsin

It is most appropriate that the State Medical Society of Wisconsin publicly recognize and pay tribute to you for your many years of selfless and dedicated service to the medical profession and to the people of Wisconsin. While nothing any of us say or do can add to the illustrious record of your achievements, nevertheless I want to add my congratulations to those of your other admirers.

But what I value equally with your genuine and manifold contributions to your fellow man is the enduring memory of our association together on so many different occasions and in so many different activities.

Time and again over the past decade when I sought your counsel on some stubborn and vexatious problem—relating, perhaps, to the Department of Public Welfare, or the American Cancer Society, or the State Hygiene Laboratory, or some problem relating to appointments or the medical profession—I found you unfailingly wise, patient, understanding, and willing to be of help.

During your long career of service you have richly earned that most honorable of all titles: Good Citizen—and Man of Good Will.

Walter Johnson

of doctors . . . valued public servant . . .

From CONRAD A. ELVEHJEM, Madison
President, The University of Wisconsin

I was delighted to learn that the *Wisconsin Medical Journal* is planning to recognize you for the many contributions which you have made to the medical profession and to everyone connected with Wisconsin.

When I came to the University of Wisconsin as a freshman in 1919, your name was already well known. It was therefore a real privilege for me to become better acquainted with you down through the years. First I knew of you as a scientific worker in the field of medicine, with a genuine interest in making the findings of the laboratory available to the practicing physician. Later I knew you as Director of the Hygienic Laboratory—and as a neighbor across the mall, I watched with much interest the construction of the laboratory which has grown to be such an important part of the Medical School and the medical profession here in Wisconsin. It was your leadership which made this fine structure available so that all the necessary services could be carried on under one roof.

But, more important, were the personal visits we had and your genuine interest in all of us who attempted to make some contribution in the field of medicine. Your interest in our work was most stimulating to all of us. Your interest was especially evident when you made available space in the new laboratory for work which some of my colleagues could not carry out because of lack of space.

Although you retired the same time I took over the position of President, I have greatly cherished our contacts during the past three years. Your activity, during this so-called retirement period, has been most helpful to the Medical School and to the University. Your personal advice to me during the past three years is deeply appreciated.

Thus, I am especially happy to salute you on this occasion—a time when you are completing almost 50 years of service to Wisconsin!

C. A. Elvehjem

From E. B. FRED, Madison
President Emeritus, University of Wisconsin

For more than 47 years you have devoted your efforts to ways and means of improving the health and happiness of the people of Wisconsin. With great foresight, imagination, good judgment, and persistence, you have carried forward the great traditions of the Wisconsin Idea—service to all. We of the staff of the University and the citizens of Wisconsin have learned to admire you for your self-sacrificing devotion to the search for truth.

Throughout the years your industry, personal charm, and integrity have commanded the respect and loyal devotion of all who have had the good fortune to come within the radius of your influence. I consider it a real honor and a privilege to have been associated with you for a number of years in the various programs of the University of Wisconsin. To a rare degree, you possess the ability to get along well with your superiors and associates, as well as with your assistants.

With the passing of the years, the Hygiene Laboratory, of which you have been Director, has grown in stature and is recognized as an important part of the health program of the State.

In the years to come, let us hope that you may continue to inspire and guide others who select the medical field for their life's work. May you be given many happy years in which to enjoy the fruits of your great contributions to the welfare of Wisconsin.

E. B. Fred

From JOHN Z. BOWERS, M. D., Madison
Dean, University of Wisconsin Medical School

I welcome this opportunity to express my respect for the manifold contributions which you have made to medicine in Wisconsin, the nation and indeed the world. It is customary to refer in such testimonials to past accomplishments, but I prefer to cite your present achievements.

As Coordinator of our program in Continuing Medical Education, you were willing to take on a tough challenge. There was a clear need for stimulating faculty interest for developing a comprehensive program and for enhancing our relations with physicians across the State. The record shows that all of these goals are not only being accomplished—you have exceeded them. Our program has made a real impact in Wisconsin and is now drawing national recognition with 20 states represented among the registrants.

You are a real trail-blazer and happily like a product which you occasionally consult, you improve with age.

John Z. Bowers

man of good will . . . man of dedication . . .

From CARL N. NEUPERT, M. D., Madison
State Health Officer, Wisconsin State Board of Health

It is a very special privilege along with a few of your many, many friends who deeply respect and admire you to acknowledge sincere regard for you as an outstanding man among men, as a scientist, a teacher and above all as one dedicated to the improvement of health and well-being of fellow citizens in all walks of life.

Over the 47 years to date that you have devoted to advancing the well-being and fuller life of others in so many constructive ways since coming to Wisconsin you have been significantly effective in advancing the health of all of us by way of the application of the medical sciences to the diagnosis, treatment and prevention of disease and to the development of environmental sanitation in a remarkable way.

It is not possible in a letter like this to enumerate even the most outstanding of these accomplishments as you served in your capacity as Director of the State Laboratory of Hygiene for 45 years, as Professor of Hygiene at the University of Wisconsin Medical School teaching medical students and all of us so effectively, as well as through your outstanding leadership of the physicians of the state and nation in your capacity as President of the State Medical Society and as its delegate to the American Medical Association over the years.

Your role in the advancement of the prevention and control of cancer has been outstanding. Your accomplishments as Chairman of the State Board of Public Welfare and your active promotion over the years of medical history indicate some measure of the tremendous breadth of your being.

What a man!

It's a very special privilege to know you and to be one of your many friends.

Carl N. Neupert

From WILBUR J. SCHMIDT, Madison
Director, State Department of Public Welfare

I deem it a privilege to have this opportunity by open letter to express the highest regard for your achievements and contributions to the common good of our citizens, through your efforts in the field of preventive medicine, public welfare, and medical education.

My firsthand knowledge of your activities is most complete, of course, in the field of public welfare. You have served for almost two decades as a member and Chairman of the State Board of Public Welfare. Without question, your long-range vision, insight into the health, social and economic needs of our people, and your devotion to the cause of a high standard of public service, have enabled you to make a substantial contribution toward the development of public welfare services in Wisconsin to the high standards of quality and adequacy we enjoy today.

I also wish to express my admiration for you on account of your personal qualities which include, among the many virtues, honesty, a warm personality, courtesy, and a sense of fairness, along with firmness in your convictions, and persistent dedication to purpose.

As you are now beginning a new six-year term as a member of the State Board of Public Welfare and continue to serve as its Chairman, I am looking forward to your continued guidance and effective effort in this sphere of public service.

Wilbur J. Schmidt

From ALFRED S. EVANS, M. D., Madison
Director, State Laboratory of Hygiene

The President of the United States has recently said: "Of those to whom much is given, much is required. And when at some future date the high court of history sits in judgment on each one of us —recording whether in our brief span of service we fulfilled our responsibilities to the state—our success or failure, in whatever office we may hold, will be measured by the answers to four questions."

To each of these questions, you, Doctor Stovall, can answer "Yes":

Yes—you are a man of courage—with the courage to stand up to one's enemies and when necessary to your own associates.

Yes—you are a man of judgment—able to perceive the future as well as the past.

Yes—you are a man of integrity—who never deserted the principles in which you believed, or the people who believed in them.

Yes—finally, you are a man of dedication—devoted solely to serving the public good and the national interest.

And there are the qualities which, with God's help, will continue to characterize you in the still fruitful years ahead.

A S Evans

trail blazer . . . man of judgment . . .

From ARTHUR P. SCHMIDT, Milwaukee
President, Wisconsin Welfare Council

It is with great pleasure that we of the Wisconsin Welfare Council learn of the State Medical Society's plans to issue a special publication of the *Journal* in honor of you, and that we are invited to participate in this tribute which you so richly deserve.

Your numerous and outstanding contributions to the general welfare of people in Wisconsin, both in and outside of your capacity as Chairman of the State Board of Public Welfare, are well known and admired by members of this organization. A large number of outstanding public welfare services and programs in this State stand as living monuments to your zealous and untiring efforts toward the betterment of the lives and living conditions of all people.

On behalf of the officers, board of directors, and members of the Wisconsin Welfare Council, we salute you, Doctor Stovall.

Arthur P. Schmidt

From GEORGE F. LULL, M. D., Chicago
Former Secretary and General Manager, American Medical Association

Although you may have reached the age of retirement, you have not reached the age of where you can be put on the shelf and not utilized. Your past history is one of which you as well as your friends can be justly proud. Very few men can look back upon a full life such as yours, including teaching, professional work, as well as many activities in connection with organized medicine.

I hope that we will be able to meet in the years to come at various medical meetings similar to those at which we have met in the past. It has always been a great pleasure to see you and talk to you at these all too infrequent times.

Again, my congratulations and best wishes.

George F. Lull.

From ROBERT S. HAUKOHL, M. D., Milwaukee
Secretary, The Wisconsin Society of Pathologists

The members of the Wisconsin Society of Pathologists wish to join the members of the Medical Profession and the people of Wisconsin in recognizing your outstanding contributions to Preventive Medicine, Public Welfare and Medical Education over the years.

As a Member of our Society, you have already been honored by elevation to the status of "Honorary Member." It is only fitting that the friendship and wise counsel that you have given to us over the years will now be publicly recognized. I am sure you know of the high regard we hold you individually, and we are now pleased to again recognize you as one of the Fathers of Pathology and Laboratory Medicine in Wisconsin.

Robert S. Haukohl

From GEORGE F. CRIKELAIR, M. D., New York City
Former Student and Personal Friend

It is a pleasure and an honor to join with the Editors and the Editorial Board of the *Wisconsin Medical Journal* on such a joyous occasion.

Your good influences have been ever present since our first teacher-student meeting 19 years ago. Happily, they have grown appreciably over the years. Despite your many activities and commitments, you have ever been available for advice, counseling and help which has been deeply appreciated; your philosophies have deeply influenced every medical circle of which any of us has ever been a part.

I personally recall with pleasure our meetings once or twice each year in various corners of the United States. Most vividly I recall our last one here in New York a few weeks ago when the matter of surgeon-pathologist relationships occupied us for an entire evening.

Appreciation for the personal and professional kindnesses and services you have rendered to all of us cannot be expressed in words; it can be shown by our following your example and practicing your teachings so as to ever broaden the scope of your influence. Your contributions are not confined to the State of Wisconsin—they are global, as is our appreciation.

G. F. Crikelair

firmness in conviction . . . man of integrity . . .

From F. J. L. BLASINGAME, M. D., Chicago
Executive Vice-President, American Medical Association

I am pleased and honored to be invited to join with other friends in expressing gratitude and appreciation for the oustanding services that you have rendered in medical education, preventive medicine, and the public welfare.

Out of respect of your talents, your professional colleagues have called upon you to assume duties at all levels of organized medicine; and you have discharged these responsibilities in such a manner as to merit the devotion, gratitude, and respect of your fellow physicians, as well as a host of laymen.

I recall most vividly your effective work as a member of the House of Delegates of the American Medical Association. You were ready to discuss in an informed fashion many complicated problems; and your incisive mind has often served to clarify issues and point out reasonable solutions. This same type of accurate thinking on your part has made you a most valuable member of the Council on Constitution and Bylaws.

Praise and honor to you and best wishes.

F. J. L. Blasingame

From LELAND S. McKITTRICK, Brookline, Mass.
Chairman, AMA Council on Medical Education and Hospitals

It has just come to my attention that some of your many friends and co-workers want you to know that occasionally a prophet is not without recognition in his own land. I am very grateful to them for having included me in this family circle.

My knowledge of you goes back much farther than your knowledge of me. For some reason, maybe I will never know why, Stovall was a name held in high regard during my student days in Madison. After I left Madison in 1916 many years elapsed (during which I grew up a little more and you probably became a shade more mature) before our paths began to cross as members of the House of Delegates of the American Medical Association.

Even in the House one does not always fully appreciate the many talents of our associates and it was not until I was elected to the Council on Medical Education and Hospitals that I came fully to realize the tremendous tower of strength which you and relatively few others in the House of Delegates were to us on the Council.

One of the sources of real satisfaction to me in recent years, one of the really great rewards from my work on the Council has been the privilege of coming to know better a select few like yourself whose breadth of interest and deep devotion to medical education, to the practice of medicine and to the people we serve makes us proud of our profession.

I am pleased that the Editors and Editorial Board of the *Wisconsin Medical Journal* are taking the initiative of showing appreciation for the privilege which has been theirs of working with you and I am particularly proud that our association of the past makes me eligible to be included.

With a deep sense of appreciation for all that you have done and continue to do, I am

Mac

From GUNNAR GUNDERSEN, M. D., La Crosse
Past President, American Medical Association

Forty-four years ago I had the good fortune of being in your class on the top floor of old South Hall. This was our first contact. What I learned then about you, your talents, dedication, devotion to principles and your activities generally have since been confirmed in innumerable different fields, in different places and under different circumstances.

I know of no one to whom the physicians of our State, and more importantly the citizenship of our country, are more indebted than to you for your selfless devotion to not only your chosen field of medicine but also to your public spirit and contributions in the fields of Preventive Medicine, Public Welfare and Medical Education. You have indeed been a medical statesman of the first rate.

I sincerely trust that we all shall have the continuing benefit of your services for many years ahead.

Gunnar Gundersen

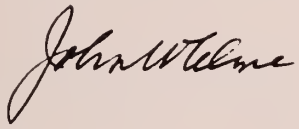
a medical statesman of the first rate . . .

From JOHN W. CLINE, M. D., New York City
President, American Cancer Society, Inc.

It has been a great pleasure to know you and to work with you over the years. You have always been an extremely sincere person with the capacity to go to the heart of the matter incisively and to express your views forthrightly and with clarity. These characteristics are not as common among men as we all might wish.

Your service to our profession through its organizational activities and your splendid work in the fields of medical education and preventative medicine leave us all in your debt. I am particularly appreciative of the splendid work you have done in Wisconsin for the Cancer Control Program.

I consider it an honor to be able to join with your many friends in expressing appreciation of your great contributions.



From RALPH C. FRANK, M. D., Eau Claire
President, Wisconsin Division of American Cancer Society

Being asked to address a letter to you for publication in this commemorative issue of the *Wisconsin Medical Journal* is actually a very great honor. Upon looking over the astounding list of accomplishments you have achieved, the list of medical societies to which you belong, and the innumerable honors which have so rightly been bestowed upon you, I realize there is no honor I can pay. On the contrary, one is very definitely bestowed upon me for being given the opportunity to acknowledge your influence upon my own medical career.

Not only have your contributions through the State Laboratory of Hygiene had a profound effect upon the development of modern Laboratory Medicine in this state, and consequently upon every practicing physician in Wisconsin today, but your cofounding of the present Wisconsin Division of the American Cancer Society and continued active and vigorous interest in that organization have had tremendous effect in educating the non-professional citizens of this state in the important role the individual must play in combating the Cancer problem. I know of no man who has influenced so greatly either the medical profession or the public, and it is therefore even more remarkable to note your tremendous influence on both of these groups.

Your leadership in the Cancer Society has been an inspiration to me, and I know that all men will join me in attesting that when you speak you do so fearlessly and in complete honesty with never a hint of self interest or aggrandizement.

This commemorative issue of the *Journal* marks no retirement accolade, for you will never retire. This simply marks another of the many great tributes you have deserved so richly.

May I extend my heartiest congratulations and also my personal thanks for setting high and inflexible standards another can at least admire and wish to attain.

From GEORGE F. KASTEN, Milwaukee
President, Milwaukee Division of American Cancer Society

It is indeed a pleasure for me, on behalf of the Directors and Members of the Milwaukee Division of the American Cancer Society, to express our sincere appreciation to you for your many contributions to the cancer control program of this State.

The tributes rendered to you at this time by so many individuals and groups are richly deserved.

As a physician, teacher and counselor, your efforts in preventive medicine, public welfare and medical education have benefited literally every citizen in Wisconsin.

From ARTHUR J. McCAREY, M.D., Green Bay
Vice-President, Charitable, Educational and Scientific Foundation

"Because the individual is the ultimate unit of our Society toward whom all of the practices for the improvement of human welfare are directed and because the welfare of the individual determines, in the last analysis, the welfare of the group, it behooves us in planning social welfare to keep focused on him."

These words were expressed by a President of the State Medical Society of Wisconsin in 1948.

a man of and for the individual!

They are the words of Doctor Stovall . . . and they capsule the philosophy that has made him a statesman among physicians, a counselor to the civic-minded, and a social benefactor to all the people of Wisconsin.

With this spirit of "individualism" he has nurtured the Charitable, Educational and Scientific Foundation of the State Medical Society. As its President since its inception in 1955, he has seen that the Foundation is a useful and desirable instrument of the profession and society only if it serves the individual. To this end he has helped to build a Foundation through which physicians may be enlightened in scientific medicine, medical students aided in their time of financial difficulty, and the M.D. assisted when a victim of misfortune. He has foreseen, too, the inestimable value of the Foundation in helping the teen-ager to better know his body and understand its care, the parent to improve family health habits, and the student to have a clearer understanding of medicine in relation to the progress of man.

Doctor Stovall is a man of and for the individual. The physicians of Wisconsin would do well to adopt him as their personal "doctor of social philosophy," for his is the warm, compassionate character for which every patient longs.

Arthur J. M. Carey

From A. P. SCHOENENBERGER, M.D., Madison
President, Dane County Medical Society

The Dane County Medical Society is proud to join the State Medical Society in honoring you for a four-decade span of outstanding service to the people of Wisconsin as a distinguished physician devoted to public service.

In your chosen field of preventive medicine, you have made salutary contributions to safeguard the health of the public by extending the superior facilities of the State Laboratory of Hygiene to the far regions of the state so that none should be deprived of the services because of inability to pay.

The measure of your capability as a teacher was not realized by the sophomore student in the course of laboratory diagnosis, but the range of your knowledge in the field of preventive medicine came to fruition in your informal discussions on public health with the senior students. I had the privilege of sitting at your side to be indoctrinated in the intricacies of microdiagnosis with your infinite tact, forbearance and wisdom.

Upon joining the faculty of the University of Wisconsin Medical School, you were fully aware that the strength of leadership and the influence exerted thereby lay in participation in the activities of the County Medical Society, which you joined in 1914. Since that time, your active contributions to the County Medical Society have been numerous. Your judgment and wisdom have helped immeasurably to maintain that enjoyable and cordial relationship between the faculty and the practicing physicians. Your efforts have been sincerely appreciated and you have enjoyed the distinction with few doctors to have been elected as president of the State Medical Society of Wisconsin. With age you seem to have become more sagacious. Your advice and suggestions to the Society as A.M.A. representative and thereafter is deeply appreciated.

My colleagues of the Dane County Medical Society join me in saying THANKS and may the fall of your life be bright and long.

A P Schoenenberger

From the STAFF of the State Medical Society

The staff of the State Medical Society simply could not put this issue of the Journal "to bed" without echoing fervently the praise of Doctor Stovall written so well by so many others.

"WDS" are familiar initials to us. They are almost synonymous with many of the SMS projects: the Foundation, the Student Loan Fund, the Museum of Medical Progress, the Section on Medical History, and the "Home of the State Medical Society."

In another sense "WDS" personifies the total interest of the medical profession in its high civic responsibility. No matter how the fabric of medicine is cut in Wisconsin, there is inevitably threaded the interest of "WDS."

We of the staff are proud and happy of our associations with him.

Doctor Stovall as he appeared during his early days at the University of Wisconsin.

William Davison Stovall

A TRIBUTE TO A PERSONALITY

By WILLIAM S. MIDDLETON, M. D.

Washington, D. C.

WILLIAM DAVISON STOVALL, a name with which the present and future generations of Wisconsin men and women, lay and medical, may well conjure for many reasons. From the propitious day that Bill Stovall was brought to the State Laboratory of Hygiene in 1914 by the colorful Mazyck P. Ravenel, he has been a potent force in every movement for the health and welfare of the citizens of this State. A glance at his curriculum vitae (WHO'S WHO, 1960–1961) —and it must be accurate, for Bill wrote it! —affords some idea of the breadth and the catholicity of his interests.

This circumstance recalls an amusing incident in an earlier Legislative Committee hearing. Bill was supporting a proposal relating to some public health measure. To give force to his position, he enumerated the various posts he had held with the time spent in each capacity. A more attentive Assemblyman made notes the while. When Bill had concluded his statement, this Assemblyman asked him his age. When he answered, "Forty-one," the Assemblyman said, "I have been taking account of your various activities, Doctor Stovall. If my figures are correct, you must have graduated from the Medical School at the ripe age of 14." Taken aback, for once Bill was speechless.

As implied, Bill's fine enthusiasm and fervid initiative have carried him into many fields of human endeavor. Always he has been the crusader in the public weal. Other friends and associates will bear testimony to his sustained and effective activities in organized medicine, cancer control, public health and the State Board of Public Welfare. Indeed, separate volumes could be written on his participation in any of these vital areas. From his University of Wisconsin activities, I shall single out his relationship to the State of Wisconsin General Hospital (University Hospitals) for especial attention, for in its various ramifications Bill Stovall's splendid

Doctor Middleton is Medical Director, Veterans Administration, and former Dean of the University of Wisconsin Medical School.

qualities of leadership and teamsmanship stand in the boldest relief.

With the opening of the State of Wisconsin General Hospital in 1924, Bill assumed direction of the Clinical Laboratories in addition to his primary duties as Director of the State Laboratory of Hygiene. The functions of the Surgical Pathology Division of the Hospital Laboratories were conducted by Doctor Edgar M. Medlar, of the Department of Pathology of the Medical School. The insistence of the then Professor of Surgery, Carl Hedblom, that the pathologist stand by for frozen sections of the lung for 3 to 5 hours led to a sharp schism (1926). The Department of Pathology refused to tolerate what it considered cavalier treatment at the hands of Surgery and withdrew its support of these functions. Whereupon Bill Stovall was asked to assume this added responsibility. With characteristic energy, he plunged into this unaccustomed field. With the support of young associates, most recently Doctor Walter H. Jaeschke (since 1935), he has made this vital element of the University Hospitals not only an eminently effective service unit but a respected training center in surgical pathology. To him, therefore, fell the direction of the Clinical Laboratories from 1924 until his retirement and the fires of his enthusiasm were never banked or drawn.

To an almost forgotten element of his services to the State of Wisconsin General Hospital and the Wisconsin Orthopedic Hospital for Children, due attention must be called. In 1938, Doctor Robin C. Buerki, Superintendent of the Hospitals, was invited to serve as Director of the Study of the Commission on Graduate Medical Education. It was an honor and a call to duty that could not be ignored. To the Administrative Committee of the Hospitals (Doctors Joseph S. Evans, Erwin R. Schmidt, William D. Stovall and William S. Middleton) fell the serious duty of naming an Acting Superintendent for the period of his leave of absence. After due deliberation, Bill Stovall was asked to assume this added burden. The medical wheel-horse that he has always been, he accepted the challenge and for two years (1938–1940) rendered outstanding service. His close rapport with the physicians of the State strengthened the ties that had been established by Bob Buerki and the respect in which he was held by the citizens at large further enhanced the existing confidence of the County Judges. When he returned the duties to Bob Buerki, the stature of the Hospitals had grown appreciably.

And so the story of Bill Stovall's contributions might be expanded in many directions. Others will relate his efforts culminating in the erection of the Psychiatric Institute. Many will point to the State Laboratory of Hygiene as a lasting monument to his memory; but I would close on a much more personal note. On the death of Dean Charles R. Bardeen (1935), there was much speculation as to his successor. Doctor Joseph S. Evans was then the most influential member of the Medical Faculty. He called me into his office and told me that he was exerting the utmost pressure to have Bill Stovall named Dean and asked my reaction. I was most enthusiastic in my support. Apparently, President Glenn Frank had not yielded to Doctor Evans' persuasive powers, for he shortly called me into his office and offered me the post. Reluctantly, after three days of thoughtful consideration and conferences with my associates, I accepted the Deanship. To the everlasting credit of Bill Stovall, there was never a rift in our friendship. Honor and recognition have become commonplace to this outstanding member of our Medical Faculty and fraternity; but to me the true measure of the man comes in his reaction to adversity. Osler has well phrased the Bill Stovall I know and hold in such high esteem and affection, "to cultivate such a measure of equanimity as would enable me to bear success with humility, the affection of my friends without pride and to be ready when the day of sorrow and grief come to meet it with the courage befitting a man." I salute you, Bill, my tried and trusted friend in sunshine and in shadow.

WHEN YOU REALLY come to understand it and when you stop to think about it, the very basis of all welfare is health. . . . If there is no health, you cannot promote good welfare.

—*W. D. Stovall, M.D.*

Doctor Stovall as he appeared during his tenure as director of the State Laboratory of Hygiene.

William Davison Stovall

THE HAND OF HOPE AND HUMANISM

By MRS. KONRAD C. TESTWUIDE

Sheboygan, Wisconsin

TODAY IT IS considered routine for a Wisconsin Women's Club to book a doctor to speak on cancer at one of their regular meetings. A choice of well qualified specialists is now available throughout the state for such an assignment. But such decidedly was not the case as recently as 1931, or should I rather say as early as 1931. As president of our own Sheboygan Club that year, I had requested that the health chairman should try and provide a program on the subject of the "Hopefulness of Cancer." Selecting a speaker in 1931 involved no choice, the one and only outstanding candidate for the job was Dr. William D. Stovall, then the Director of the Wisconsin Laboratory of Hygiene. His work in the field of cancer control was even then well known.

Doctor Stovall very graciously accepted the challenge to speak to our club women on the subject: "What We Know About Cancer And Methods Employed In Its Control." After the meeting was scheduled and it was publicized that Doctor Stovall was going to talk to the women about such an intimate a subject as cancer, many of our faithful mem-

bers made it known to me that they questioned the propriety of such a program. They advised me not to expect them to be seated in their usual places toward the front of the hall. If they attended, it would be with reservations. It was generally considered presumptuous and indelicate to present such a program.

Imagine my relief and delight at seeing that these reticent members were the first to make their way up to the platform after the program to ask questions of Doctor Stovall and express their appreciation for his talk. The *Sheboygan Press* of Feb. 4, 1931, reported: "Speaking cautiously yet openly as a helpful discussion warranted, Doctor Stovall asserted that apparently the disease is on an increase. 'I have no pessimism about it and I look for no hysteria,' hopefully declared the speaker. His hopefulness was based on the progress which science has made in the past 50 to 75 years in overcoming diphtheria and tuberculosis. Typhoid, too, has almost vanished from the records of this state. The doctor looked for equally effective preventatives for cancer in the distant future. . . . 'We are not able to bring relief in its (cancer's) prevention. We are just beginning to consider it. It needs your cooperation to bring this about. If the people become aroused, a great deal can be done for its prevention. There never was a time when the interest and welfare of every person was considered the responsibility for the entire community as now. This realization is becoming more and more graphic.' "

Less than a year after Doctor Stovall spoke in Sheboygan in 1931, the State Medical Society of Wisconsin appointed its first Committee on Cancer with Doctor Stovall as chairman. After this committee had completed a very comprehensive study of the cancer problem in Wisconsin, Doctor Stovall was encouraged to ask the cooperation of the "Wisconsin Federation of Women's Clubs" in combating this common enemy. Mrs. Fred Clausen of Horicon was the state president at the time and she accepted the responsibility to help Doctor Stovall recruit volunteers from the entire state for a "Women's Field Army" to crusade against cancer. The doctor with his contagious enthusiasm and Mrs. Clausen with her administrative abilities, stumped the state and met with great success in selecting and training an active feminine combat force. Until 1946 the lay participation in the Wisconsin Society continued as the "Women's Field Army" under the capable direction of Mrs. Clausen and her successor, Mrs. Irma Stoddard.

Although it was not until the thirties that I was introduced to the cancer movement, through the "General Federation of Women's Clubs," Doctor Stovall must have had a keen appreciation of the far earlier relationships that existed between the Federation and the first cancer society. It seems appropriate to mention here that back in 1913 when the prominent Dr. Clement Cleveland met with seven other physicians and five laymen to organize a cancer society, that Doctor Cleveland's daughter, Elsie, was the woman behind this great man. It was Elsie, Mrs. Robert G. Mead, who had recruited the five influential and affluent laymen and it was with the help of her enthusiasm and philanthropic astuteness that the nascent American Society for the Control of Cancer kept on functioning. Her respect for the ability of men in high places to aid a worthy cause was equalled by her estimate of the power of women, especially organized women, to do benevolent work. It was Mrs. Mead who first appealed to the well organized Women's Clubs to help further the society's purpose: "to disseminate knowledge concerning symptoms, treatment and prevention of cancer, to investigate conditions under which cancer is found and to compile statistics in regard thereto."

As one old soldier of the Field Army to her Captain, I salute you, Doctor Stovall. May you enjoy the fruits of your labor as a veteran, even as they have secured the happiness for so many.

THE RELATIONSHIP of the individual to groups and groups to the individual in society may aptly be compared to the individual cells of the human body and the body as a whole. The cell is the ultimate element in life, and the summation of the actions of all of the cells constitutes human physiology; so the individual man is the vital force in any social order, and the summation of his actions constitutes the physiology of society.

—*W. D. Stovall, M.D.*

Physicions listen to o lecture on chemotheropy ot o recent foll concer scrimmoge ot the University of Wisconsin—one of the most effective methods of direct communication between the scientist ond the procticing physicion.

William Davison Stovall

AND THE AMERICAN CANCER SOCIETY

By E. S. OLSON, M. D.

Rocine, Wisconsin

DR. WILLIAM D. STOVALL has had a deep and an abiding interest in the American Cancer Society. Doctor Stovall was co-founder of the Wisconsin Division of the American Cancer Society. He was a charter member of the Board of Directors and has continued on the board. He is presently on the Executive Committee of the Society. He received the Annual Distinguished Service Award of the Wisconsin Division of the American Cancer Society in 1949. His lifesaving effort in cytology is also well known. Other recognitions are listed in "Who's Who in America."

Doctor Stovall not only served in important responsible positions in the Society, but he also accepted lesser appeals for service at the grass roots. He has travelled 100 miles to a village with a population of 413 on repeated occasions to address volunteer workers at the beginning of a campaign. Doctor Stovall's stimulus resulted in successful campaigns.

Because of the activities and stimulus of the American Cancer Society, cancer is being attacked with greater vigor than any other disease known up to the present time. The American Cancer Society has a threefold program; namely, research, education and service to the patient.

The Society has allocated $69,000,000 for research since 1946. The Society had 650 grants for research which amounted to $17,661,470 as of September, 1960. There will be further references to research in the text.

The American Cancer Society has expended about one million dollars to develop cytology and train technicians to reduce the mortality from cancer of the uterus. Doctor Stovall has been interested in this program from the very beginning.

Ten years ago there were about 23,000 deaths from this condition each year. Now, there are about 14,000 deaths annually. The American Cancer Society has prepared an excellent educational film on this subject for the public. Practically no one has to die from this disease today if she is properly educated. This is a great accomplishment in itself.

Cancer of the breast is the commonest tumor of the female. Only about 50% survive at the present time. The American Cancer Society has prepared an excellent educa-

tional moving picture on the technic of self-examination of the breast. Earlier diagnosis could save 30 to 40 per cent more of these patients.

Cancer of the bowel is the most common malignancy that kills both men and women. Forty thousand died of this disease in 1960. If this continues, 2,000,000 persons who are alive today in the United States will die of this disease. The American Cancer Society will shortly release an educational film on this subject. A recent article indicates doctors also need some education in the early detection of this disease.

The deaths from cancer of the lung were 2,500 in 1930. In 1960, the deaths skyrocketed to 36,000. The American Cancer Society made an extensive study of this problem. Twenty-two thousand volunteers followed 188,000 men for four years who were between the ages of 50 and 70 years. Of this group 11,870 died. Lung cancer death rates were more than ten times as high among one-pack-a-day smokers than among men who never smoked. If two or more packs a day were smoked, the incidence was more than 60 times higher. Certain other cancers are also more prevalent in heavy smokers. The last International Cancer Congress in London reported similar views on this subject.

It is estimated that 1,000,000 of our present school children will die of lung cancer before they reach the age of 70 if present smoking trends continue. The American Cancer Society has prepared a film strip on this subject which is available free upon request to schools and others who deal with this age group. There were 21.8 billion more cigarettes smoked in 1960 than in 1959. This is a 4.8% increase. Premature births are said to be more frequent if the mother smokes one or more packs per day.

Next to lung cancer, leukemia shows the highest rate of increase. There is no known reason for this. There are about 11,000 deaths from this cancer, and it takes the lives of about 2,000 school age children each year. This is not far short of the national death rate from all forms of tuberculosis. More children between the ages of 1 and 15 die of cancer than from any other disease. Leukemia is responsible for half of these deaths. The American Cancer Society has allocated about $1,000,000 to study this disease. It has also allocated $1,250,000 in viral research which may be a factor in this condition. Extracts of brain tissue from humans with leukemia is reported to induce leukemia in animals.

There are about 300,000 American children under 18 who have lost their fathers and about 240,000 have lost their mothers this past year from cancer deaths.

It is estimated that one in four Americans now living will eventually have cancer. About 1,000,000 of our citizens have been cured of this disease. About 85,000 die needlessly from cancer each year.

Alexander Hamilton felt that all human action proceeds from self interest. If this is true, we should all have a deep interest in cancer.

Cancer actually overtakes heart disease when we consider premature deaths from this disease along with the supreme suffering, abysmal depression, pathetic family disruption and dissolution from this disease. The economic loss is staggering. The total annual hospital bill is estimated to be about $350,000,000. About $173,000,000 a year are lost in wages.

A monumental directional attack has been made on cancer through the stimulus of the American Cancer Society. The society is operated by volunteer Board of Directors, half of whom are professional men. Thirty per cent of its funds are allocated for research; 31% for educational purposes, and 23% for services to the cancer patient. The latter includes such items as dressing, services of visiting nurses, and other incidental assistance. Nine per cent is used for fund raising and 7% for administration.

Doctor Stovall and those of us who understand the three-fold program of the American Cancer Society and know what has been accomplished believe this Society must maintain a vigorous, independent and expanding attack on this disease. The urgency and the magnitude of the task before us makes this mandatory.

It has been stated that "anybody who has any part in fighting cancer has a job as great as landing on the moon." This means we have hard work to do and loads to lift. We cannot shun the struggle by delegating important responsibilities to others if we hope to relieve society of this terrible disease. We must take matters in our own hands, as Doctor Stovall did, if we wish to make progress in the control and treatment of cancer.

A Wisconsin Voluntary Health Agency in Action

By LOWELL LUEPTOW

Madison, Wisconsin

TWO PICTURES hang from the conference room hall at the American Cancer Society, Wisconsin Division office at 704 East Gorham Street in Madison. One is of the late Mrs. Eleanor Clausen of Horicon and the other is of Dr. William D. Stovall. Simple brass plates identify the two as "Co-Founders of the Wisconsin Division."

A coincidence of interest is the fact that the Division office is housed in the former quarters of the Wisconsin State Medical Society. It was with the support of the Medical Society that the then-infant American Cancer Society took its first steps in Wisconsin. The warm and sincere relationships which have continued to exist between the two societies is a tribute to Doctor Stovall.

More important than its early development, however, is the evolution of the three-fold program now being conducted by the American Cancer Society in Wisconsin and the nation. Early pioneers in the movement, including Doctor Stovall, had the responsibility of making a decision on the direction of the program. The nature and size of the cancer problem, the doctor-patient relationship, prevailing social and public attitudes toward cancer, and existing governmental programs—all of these factors were considered and weighed against the existing and expected resources. It matured into a healthy program which has potential for future growth.

The three-fold program of cancer control and prevention includes cancer research, professional and public education, and service. The program is supported by a combination of resources: the more-than $30,000,000 contributed annually by Americans, the more-than 2,000,000 lay volunteers who raise the money and carry out the program, and the more-than 13,000 physicians who have accepted Board memberships at national, state and local levels. All of these resources are blended under the Sword of Hope of the American Cancer Society into a live, vibrant creation aimed resolutely at the solution of the cancer problem.

Cancer Research

In cancer research is the hope for a future free of cancer. Since 1945, the American Cancer Society has funneled nearly 100,000,000 contributed dollars into a carefully designed and balanced national cancer research program. It has blazed a trail, now being followed by the gigantic federal programs under the National Institutes of Health. It served as a stimulant for the creation of federal funds in recent years, and continues to be a pathfinder toward the fullest and most effective use of dollars in support of cancer research. The Institutional Grant and the Lifetime Grant are but two creations of the American Cancer Society which government agencies are now adopting.

Public Education

While cancer research goes on, the American Cancer Society leads all efforts to take advantage of cures which already do exist for cancer. An intensive public education program has greatly increased the individual layman's knowledge of and attitudes toward cancer. Irrational fear of the disease and misconceptions, which cost lives, have been reduced while an intelligent concern and familiarity with the common danger signals of cancer have been measurably increased. The increased habit of regular periodic physical examinations has been the result of American Cancer Society messages to the public. The increased use of early diagnostic procedures such as the "Pap smear" has been the result of film showings, literature distribution, and other measures to educate the public to the fact that "every physician's office is a cancer detection center."

Mr. Lueptow is associate executive director of the Wisconsin Division, American Cancer Society.

Professional Information

The advances of cancer research in providing improved diagnostic and treatment methods of interest to the practicing physician requires swift and accurate dissemination. The American Cancer Society provides this service to physicians through several channels: periodicals such as CA—A Bulletin of Progress; professional symposia such as the annual cancer scrimmage; speakers to county medical societies in cooperation with the State Medical Society's Charitable, Educational and Scientific Foundation; exhibits such as at the State Medical Society annual meeting; and intimate coordination with the Committee on Cancer of the State Medical Society.

Service

The role of the American Cancer Society in the welfare of the cancer patient and the family must be one which can be met with few dollars per case because of the vast incidence of the disease. Therefore, the program which exists is one which relies heavily on volunteer help and which can meet the needs of the greatest number of patients. Loan closets, cancer dressings, support of Visiting Nurse Services, transportation, and other relatively inexpensive projects comprise the Service program. No funds are used for patient care or treatment. The establishment of Information Centers is the latest project, one which is aimed at helping the patient gain fullest utilization of the many community resources available. While the Cancer Society cannot and perhaps should not involve itself any closer with the patient, it recognizes its role in helping the cancer patient to realize that he is the concern of his community and of his fellow man.

The End in Sight?

The American Cancer Society is a temporary, emergency organization designed to meet the cancer problem. When the problem ends, the American Cancer Society ends. The National Board of Directors recently reaffirmed the singleness of purpose of the Society when it stated clearly that when the cancer problem is solved, the American Cancer Society will go out of business rather than turn to new health problems. Until that time, however, the American Cancer Society hopes that it will continue to deserve the cooperative and thoughtful support of the medical profession and the general public in this voluntary approach to better health.

There are two booklets available from the Wisconsin Division of the American Cancer Society which physicians can obtain by writing to Box 1626, Madison, Wisconsin. These are "Suggested Guides to Relationships Between Medical Societies and Voluntary Health Agencies" published by the American Medical Association; and "The Physician and the American Cancer Society" published by the American Cancer Society.

BORN OCTOBER 31, 1887, in Longtown, Mississippi, Dr. William D. Stovall received his general education at Mississippi College, graduating in 1908 with a B.S. degree. The son of a physician, Dr. Joseph Pendleton Stovall, he became the fourth generation to enter the field of medicine when he graduated in 1912 from Tulane University, New Orleans, with an M.D. degree. Internship and postgraduate training were spent at St. Vincent's Hospital in Birmingham, Ala., Tulane University and the U.S. Marine Hospital in New Orleans.

"I never made a real decision to be a doctor; it just seemed my own foregone conclusion to enter medicine. I wanted opportunity to do something useful to fulfill a role in life." Motivated by the family tradition, he did not follow in his father's general practitioner footsteps. Instead: " I was of the new school and different from my dad—I was fascinated by all the new wonders of chemistry, bacteriology, immunology, and the like. I wanted to be where I could use all scientific and teaching knowledge which medicine had available so I could help make people happy."

Wisconsin helped him fulfill his desires and ambitions—and Doctor Stovall helped Wisconsin fulfill its obligations of better public health.

People, and their welfare, seem to be his hobby—and his work has been his life.

The Committee on Cancer of the State Medical Society of Wisconsin

A LENGTHY STUDY entitled "Cancer Survey of Wisconsin, 1931" was published in the *Wisconsin Medical Journal* of September, 1932. This was a culmination of a two and a half year survey conducted by the American Society for the Control of Cancer. The report cited important facts concerning the facilities in Wisconsin for the diagnosis and treatment of cancer. It showed how cancer had increased in Wisconsin during the two preceding decades.

The survey report in the Journal was preceded with a "preliminary statement" by W. D. Stovall, M.D., then chairman of the Committee on Cancer of the State Medical Society. He said:

"It is hoped that this report will be stimulating and the initial plan suggested by the Committee will secure the hardy support of the hospitals and the profession throughout the State."

The plan of which Doctor Stovall spoke called for the initiation of a professional and lay educational program through the cooperation of official and voluntary agencies for the control and prevention of cancer.

In that same year, 1932, the Council of the State Medical Society established a permanent Cancer Committee and Doctor Stovall became its first chairman. The Committee was to be composed of one member from each Councilor District and that when feasible the chairman be the state chairman for the American Association for the Control of Cancer.

Such is the basic organization of the Committee on Cancer of the State Medical Society to this day.

During the ensuing years the program of the American Association for the Control of Cancer revolved around a Women's Field Army and Doctor Stovall with his Committee worked in close harmony with that organization set up under the direction of Mrs. Fred Clauson, Horicon, as "State Commander." Doctor Stovall and Mrs. Clauson traveled widely throughout the state perfecting a lay organization among women. At the same time, they were enlisting the cooperation of physicians who served as advisors to local county units of the Women's Field Army.

In 1936 Doctor Stovall and the Cancer Committee worked with the University of Wisconsin Extension Division in a series of lay and professional meetings designed to interest Wisconsin citizens in the cancer program. For ten years the close relationship of the Committee on Cancer and the new and growing lay organization was reflected in the frequent meetings of the advisory committee to the Women's Field Army which consisted of the chairman of the Committee on Cancer and another M.D. member of that Committee and the State Commander. It is interesting to note in 1941 that part of the funds collected by the Field Army were used to support a series of "Spring Clinics," a form of lay support of professional education which has continued throughout the years.

The year 1945 marked a significant change in the organization of the American Society for the Control of Cancer. It was no longer an exclusively woman's organization and two divisions were created in Wisconsin which have since come to be known as the Wisconsin Division and the Milwaukee Division of the American Cancer Society.

Doctor Stovall was closely associated with this change in national structure and took a leading role in establishing the Wisconsin Division in such a way as to assure the utmost in cooperation on scientific matters between the Wisconsin Division and the Committee on Cancer of the State Medical Society.

As a result, the State Medical Society's Committee on Cancer automatically composes the Medical and Scientific Committee of the Wisconsin Division. In addition, all members of the Medical Society's Committee on Cancer serve as members of the Board of Directors of the Wisconsin Division.

(Continued on page 551)

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Routine Vaginal Cytology

By EDWARD A. BIRGE, M. D.

Milwaukee, Wisconsin

IT IS AN unquestioned fact that the cure of carcinoma at present depends upon its physical eradication, either by surgery or by irradiation. To obtain the best results, the carcinoma should be small and should not have spread. Much effort has been given to finding methods by which carcinoma can be diagnosed earlier and earlier, so that the current methods of treatment will have more chance of success. In 1943, Papanicolaou[1] reported his results, utilizing cytological techniques for the diagnosis of cervical carcinoma. Since this time, numerous reports[2,3] have appeared, putting this method on a sound practical basis. Begun in 1948 at this hospital as a trial experiment, the method has proved to be so successful that it is currently used as part of the routine office examination by all of the gynecologists on the staff, as well as by many of the internists and general surgeons. With somewhat better than 10 years' experience, it is now possible to examine the results with a critical eye and to re-appraise the value of this type of examination.

The cytology laboratory at this hospital is self-supporting. Since a fee is charged all patients able to pay, the smears examined represent specimens taken from private patients. It must be borne in mind that these smears represent only one phase of a physical examination of the patient which also includes a pelvic examination by a competent physician. The smears examined represent a continuous age gamut, ranging from the young girl of 18 or 19 to the elderly matron of 70 or 80. The bulk of the smears are obtained from patients between the ages of 25 and 45. Many of the smears represent repeat examinations of the same patient. Of the cases on file 69.7% represent initial examinations, 18.1% of the cases have had two examinations, 8% have had three, 2.2% have had four, 1.2% have had five smears, and 0.8% of the patients have now had six or more smears over the course of the years.

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All diagnoses of carcinoma represent the confirmation of a suspicious or positive cytological smear by tissue examination of the cervix. Table 1 indicates the total number of cases screened over the years and the number of cases of carcinoma found by cytological methods. Eighty-two per cent of the cases of cervical carcinoma diagnosed at this hospital since 1950 have been found by this technique.

The method is not infallable and all abnormal smears should be confirmed by tissue examination before therapy is commenced. Since 1950, 65 false positive and 13 false negative smear diagnoses have been made. The latter 13 patients all had clinical evidence of invasive cervical carcinoma, so that the diagnosis was made by means of tissue biopsies taken from a suspicious lesion at the time the first cytological smear was made. The majority of the 252 cases represents patients who had no visible cervical lesions and in whom the diagnosis was completely unsuspected by the physician.

Inevitably, some patients have been discovered in whom the initial examination failed to disclose any evidence of abnormal cytology. Repeat smears made at a later date demonstrated abnormal cytology and tissue biopsies demonstrated the presence of carcinoma in situ. A total of 10 such cases has been recorded over the years and these cases are listed in Table 2. These cases are not con-

TABLE 1—*Cases of Carcinoma Found by Cytological Methods*

Year	Total Cases Screened	Other Pelvic Malignancy Diagnosed By Pap. Smear	New Cases Ca. Cervix
1950–52	2,170	?	23
1953	2,060	7	18
1954	3,347	7	29
1955	5,213	7	30
1956	6,829	15	36
1957	7,873	17	39
1958	8,706	16	29
1959	9,445	9	25
1960	9,763	11	23
	55,406	89	252

TABLE 2—*Cervical Carcinoma Diagnosed by Pap. Smear After Previous Negative*

Patient	Age	Year Original Smear Neg.	Year Initial Abnormal Smear	Time Interval Between Initial and Abnormal Smears (Months)
S. D.	49	1957	1959	18
B. G.	46	1956	1960	36
C. G.	62	1952	1954	18
D. G.	?	1955	1958	36
A. H.	39	1956	1959	35
L. H.	36	1957	1959	24
E. K.	34	1958	1959	12
L. S.	29	1956	1958	25
B. B.	41	1958	1959	16
M. Z.	63	1957	1960	30

sidered to be false negative because of the long time interval which elapsed between the original negative smear and the subsequent abnormal smear.

Detailed statistics for the first few years are not available. Clinical results in later patients are reviewed in Tables 3 and 4. The patients enumerated in Table 3 were treated by cervical conization alone or followed by total hysterectomy. Those tabulated in Table 4 were treated by irradiation.

Cytological studies can also be used to follow patients with carcinoma of the cervix following irradiation therapy. The cytological changes due to irradiation and described by Zimmer[4] were found in some but not all of the smears from our postirradiated patients. Many of the smears on irradiated patients show only the changes of atrophy. Occasionally the cells present seem to show a follicular effect, but it has not been possible to determine whether these individuals are receiving exogenous estrogen or if the dose of irradiation was insufficient to sterilize them.

There is a total of 74 patients in whom invasive carcinoma of the cervix was treated by irradiation, and who have then been followed by cytological methods for a period of at least one year. Only 12 of these patients have had abnormal postirradiation smears suggestive of neoplasm. In 4 of these 12 patients tissue biopsies confirmed the presence of recurrent carcinoma. Six patients had negative biopsies and are currently living and free of tumor. The remaining 2 patients had no tissue studies but subsequent cytological smears showed only irradiation changes. In addition to the patients listed above, 3 cases of recurrent carcinoma of the cervix, occurring 10 to 15 years after treatment, were diagnosed when they presented themselves anew to a physician because of recurrent symptoms. Although carcinoma of the cervix, recurrent after many years, may be diagnosed by cytological smears, interpretation of smears from postirradiated patients is more difficult and must be made with caution.

The cytological smear has proved itself to be a useful and extremely valuable means of diagnosing cervical carcinoma. The routine application of this technique annually to all women has been suggested by many authorities. The case-finding rate is quite small, but obviously to the individual in whom the carcinoma is found, the results must be considered highly significant. Practical difficulties arising from the lack of trained personnel have led to other methods of attack on the problem. Different staining methods, and automatic screening have been tried experimentally, but with little promise of success at the present time. From experience gained by the author and his colleagues[5] at this hospital, it would appear that the most practical solution at the present time lies in the proper spacing of cytological examination. From our experience the following appear to be reasonably plausible:

1. Carcinoma in situ will remain in situ for some time.
2. Examination of cytological smears by specially-trained people will disclose the

TABLE 3—*Cervical Carcinoma In Situ or Minimal Invasion*

No follow-up	18
Dead	0
Living and Well	
1 year	13
2 years	15
3 years	8
4 years	9
5 years	11
6 years	6
7 years	0
8 years	3*
TOTAL	83

*One patient with cervix clean; now has carcinoma of colon.

TABLE 4—*Invasive Cervical Carcinoma*

No follow-up	15
Dead	23
Living— ( ) Number with tumor	
1 year	12 (1)
2 years	8 (1)
3 years	8 (1)
4 years	9
5 years	8
6 years	5
7 years	7
8 years	4
9 years	2
TOTAL	102

presence of cervical carcinoma in most instances.

3. The false negatives which have been found in this hospital have all been associated with clinically-recognizable lesions.

The author and his colleagues suggest that the cytological examination of the cervix be made a part of the routine physical for all women. The smears need be obtained at intervals of approximately two years, provided that the cervix is carefully inspected and a proper gynecological examination made at the time of any physical examination. We feel that the combination of cytological screening by competent cytologists, plus a good gynecological examination by a competent physician, will do much toward eliminating far-advanced invasive carcinoma. Since carcinoma in situ and those with minimal invasion apparently respond well to treatment, the prognosis of the disease can be improved when effective methods of early diagnosis are used.

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THE COMMITTEE ON CANCER continued from page 547

At present, the Committee on Cancer of the State Medical Society consists of 13 members, one from each of the Councilor Districts in the State Society. Its principle duties are to advise the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. The members of the Committee have substantial duties within their own districts. Each is to maintain contact with the physicians in his district who are officers or advisory members of local county cancer society units. He is to be available to meet with county units of the American Cancer Society and serve as liaison between the county medical societies of the district and the county cancer units. He is to report periodically to the Councilor in each district on the status of cancer control and he is to promote in his district the control of cancer quackery, the expansion of local cytology service centers, the development of cancer registries and the coordination of professional education in the treatment of cancer.

The Committee on Cancer is currently engaged in reactivation of a Cancer Coordinating Committee including representatives of 15 organizations, both state and voluntary. This Coordinating Committee is reviewing the professional educational programs in cancer available to the physicians of Wisconsin and is taking preliminary steps toward greater coordination of public education, prevention and control of cancer quackery, establishment of tumor registries and cytology programs and increased participation in the smoking and lung cancer program of the American Cancer Society.

The coordination which has been so much in evidence for the past quarter century between the State Medical Society and the Wisconsin Units of the American Cancer Society has produced unusual progress in the control and prevention of cancer in this state. It was Doctor Stovall who perceived the importance of such a closely coordinated activity. His foresight has proved itself. As a consequence, the medical profession remains in close direction of the cancer program in Wisconsin. A position which carries with it great responsibility as well as unique opportunity.

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Pain, A Symptom of Adenocarcinoma of the Uterus

By WARNER S. BUMP, M.D.

Rhinelander, Wisconsin

PAIN IS seldom considered a symptom of carcinoma of the body of the uterus. Curtis[1] wrote: "The symptoms of uterine cancer, aside from bleeding, are of little diagnostic value." Brewer[2] says: "Pain is not a symptom unless there is extension of the malignancy into adjacent tissues, unless there are co-existing pelvic pathologic lesions, or unless there is cervical stenosis."

The purpose of this communication is to record briefly a case history which indicates that in the event of cervical stenosis, not only may pain be a symptom of carcinoma of the endometrium, but also that it may be a relatively early symptom and for a long period of time the only symptom.

Case No. P 189–61, a married nulliparous white woman, 15 years past a normally occurring menopause, presented herself for examination on Jan. 20, 1961, with the complaint of lower abdominal pain.

She stated that she remembered lower abdominal distress as early as the second week in September, 1960 (4 months previously). At this time she was traveling, eating foods to which she was unaccustomed, and had developed a semi-diarrhea with four or five loose bowel movements per day. Naturally she attributed the distress to her intestinal tract.

She continued her travels over a period of three months. On several occasions there were periods when the stools were loose. However, the lower abdominal distress continued regardless of the bowel status. Sometimes the pain was cramp-like and caused the desire to defecate even though no bowel movement resulted.

In December the distress became worse, occasionally waking her at night. Ten grains of aspirin gave considerable relief and this medication was used rather frequently. The bowel movements continued to be more frequent than usual, but by this time the patient felt that there was no definite correlation of the pain with disturbed bowel function.

About Christmas time she had an upper respiratory infection followed by severe diarrhea. After recovery from this episode, the pain continued and even became more marked, radiating to the lower back and thighs, reminding her of menstrual cramps which she had not had for years.

Abdominal and pelvic examinations were negative. The cervix uteri appeared normal and there was no abnormal vaginal discharge. It was somewhat difficult to palpate the uterus, but no uterine or adnexal enlargement was noted. No abnormal cells were found on Papanicolaou smears. At sigmoidoscopic examination (25 cm.) nothing abnormal was seen. An x-ray examination of the colon on Jan. 27, 1961, revealed no abnormality.

Suddenly on February 8 there was a discharge of a very moderate amount of blood from the vagina with complete cessation of the pain. No abnormal cells were found in cytological smears of this material. However, material obtained by suction through a small cannula was positive for adenocarcinoma on smears and tissue sections. The pain did not return and it was apparent to the patient that her distress from the beginning was caused by uterine contractions.

Carcinoma of the body of the uterus, when recognized and treated early, offers an unusually good prognosis. This case report is presented because it serves to remind us that this tumor unfortunately may have an insidious onset and may develop over a relatively long period of time without tell-tale uterine bleeding or discharge. It points out that when there is cervical stenosis, pain may be a relatively early symptom and for a long time the only symptom of endometrial cancer. It suggests, when it is difficult to find an adequate cause for lower abdominal pain in a postmenopausal woman, that the uterus be investigated even though no direct evidence casts suspicion upon that organ.

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About Colostomy Management

By ROBERT J. SAMP, M. D.
Madison, Wisconsin

MODERN MEDICINE and a century of science have not solved all our patients' problems, not even such a simple one as colostomy management. This fact is obvious after reviewing a large number of colostomy case histories. Recently it was brought home forcibly through a discovery by the Wisconsin Division of the American Cancer Society.

The Society's Service Committee reported an increase in requests for dressings prepared by the Society's volunteers. Realizing there was no parallel increase in draining, infected or massive wounds from cancer, the Society investigated the excessive need for pads and dressings. It was found that most of the supplies went to patients with colostomies, particularly those with messy, poorly controlled and improperly managed colostomies.

Conserving these expensive dressings is possible by improving colostomy training and care. Furthermore, the controlled, cleaner patient has a higher morale, more social acceptance, and regains his self respect. The number of these operations is increasing as more people enter the colon cancer age group. Palliative colostomies are increasing and adding months to patients' lives. Answers are needed on training techniques, control, and care. It is easy to see why a colostomy education program was launched by our State Cancer Society and why colon and rectum cancer information is being stressed in 1961.

The efforts have largely centered around the work of nurses, since much of the colostomy burden is transferred to them. Nursing instructors and surgical nurses care for and train the majority of new colostomy patients. These teachers teach future nurse teachers as well as county, public health, school, rural and visiting nurses.

The Cancer Society offered cancer teachers and surgical nurses in Wisconsin nursing schools pamphlets, books, speakers, and programs on care of the colostomy. In 1961 over 2,000 major pieces of literature were ordered by the nurses. Seventeen conferences, classes, or demonstrations were conducted by as many doctors and nurses.

The practicing physician has not been neglected or bypassed in any way. The State Medical Society Committee on Cancer supported the Division plan of increased emphasis on education in colostomy care, especially as directed toward nurses. The professional information committee of the Wisconsin Cancer Society recognized that the nurses are already performing a yeoman task in taking over the instruction of new colostomy patients and gave its endorsement to the program.

Old and New Facts

New studies and techniques of colostomy control are not plentiful. Teaching materials, other than the Cancer Society's "Care of the Colostomy" brochure and the "Nurses' Manual on Colostomy Care," are scarce. I was able to find only one film on colostomy management. It was a minute and a half sequence in black and white from England, pre-war and silent, showing a head-on, close-up, midline colostomy emptying sporadically into a kidney basin. Needless to say, the possibility of a Cancer Society film in 1962 is encouraging.

The medical literature offers little in recent or new studies. Our own tumor clinic's Survey of Colostomy Patients[1] in 1957 *still* draws correspondence and inquiries. These facts plus a review of over 250 clinic colostomy patients and their minor but numerous

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complaints made it evident that there is a need for more studies and answers. Problems with a colostomy are greater than realized.

Further clinic patient studies and interviews were carried out as a result. The outpatient tumor clinic afforded ample cases of permanent colostomy (Mile's Operation) at varying intervals since surgery. A high survival rate allows studies of many patients for long periods.

Ready References

A dozen teaching points were assembled by pooling previous studies with present observations, treatment results, and conclusions. These are offered as a general ready reference on colostomy management for the practitioner.

POINT 1. The physician performing the colostomy automatically assumes responsibility for the patient's training to care for it.

Comment: If the colostomy training job is delegated to nurses, the doctor must be certain they are trained properly. Periodic demonstrations to nursing teachers and surgical ward nurses is essential because interpretation can be altered by teaching and time. The demonstration is especially needed if the doctor has special techniques or management practices he prefers personally for his patients.

POINT 2. Keep the irrigation procedure simple.

Comment: Elaborate equipment is costly and soon abandoned. Our more intelligent and best controlled patients use any soft rubber irrigating tube, plain water at room temperature, dilate with vaselinized finger cots, catch in a simple basin, utilize a minimal cover (2″ x 2″ gauze held by small elastic band).

POINT 3. Dilate colostomy with fingers daily.

Comment: Irrigation without dilating eventually leads to stenosis in many. The enema tube is no substitute for the gloved and lubricated finger, patiently but firmly stretching the stoma.

POINT 4. Dilating without irrigating is ineffective colostomy control.

Comment: Many patients have been found to dilate the colostomy with finger or tube but not irrigating with water. A small movement of stool appearing at the terminal end of the bowel is misinterpreted as a cleansing. Rarely, if ever, does the finger prime the colon into a full evacuation.

POINT 5. Daily natural or automatic emptying of the colostomy (i.e. a trained bowel) is possible, but not probable.

Comment: In a small per cent of patients and usually after years of faithful irrigations, spontaneous diurinal evacuation takes place; usually at the same time the patient was in the habit of irrigating. But a complete or thorough clean-out is essential to avoid spilling, odor, gas, and noise (Point 6). It should be noted that those without colostomies have a variance in the number, time and completeness of bowel movements, despite normal bowel discipline and faithful schedules. Also there are other factors such as an effective gastro-colic reflex, conditioned response, and some abdominal muscular training (assisting evacuation by straining) which are possible altogether in very few people, unfortunately.

POINT 6. Patients fear spilling, odor, and gas the most, so prevent these from the first.

Comment: The surgery for colostomy usually decreases the fluid-absorbing surface of the bowel, cuts down colon storage space, destroys the water-tight (and air-tight, with practice) sphincter, and loses the combined muffler-baffle-safety valve mechanism of the intact lower bowel. The primary remedy to make up for this is a routine irrigation and clean-out of the colon. Improper irrigating techniques lead to messing or accidents during the day, subsequent odors from the discharge and the use of various gadgets to catch or soak up the spill (bags, thick dressings). One trouble begets another; i.e., insufficient quantity of enema, fluid is retained which spills later in the day. This necessitates external precautions, increases odor, produces noise (air entering during irrigation is expelled). A simple diet during prolonged periods of upset (as in gastroenteritis, stomach flu) is recommended. Better dietary habits (Point 9) are of help to avoid loose or over-active bowel which can increase

spilling (and hence odor, noise) between irrigations.

POINT 7. Bowel upsets are often exaggerated after surgery and on special occasions.

Comment: Patients with bowel sensitivities, allergies, idiosyncrasies, colon emotional response in their history before surgery are often just as susceptible after treatment. This is especially true around periods of follow-up examinations, x-rays, travel, excitement. Colon patients focus more than ever on the alimentary tract after something is found wrong. Their preoccupation with flowage, volume, rumblings and stool characteristics intensifies. It is helpful for the physician to know why the trouble occurs so he can reassure the patient. The doctor can divert the patient's attention away from the bowel by expressing confidence in his recovery and colostomy care, getting him back to work, getting him up and around more. Mild sedation and tranquilization for short periods is effective.

POINT 8. Full control of the bowel by diet alone is highly improbable in colostomy patients.

Comment: Many patients attest to their ability to regulate the bowel by special types and amounts of food and drink. What is nearly impossible for the person with an intact colon cannot be attained in a colostomy patient. Careful history and honest reporting of daily bowel habits reveal a minor degree of timed evacuation, but results are inconsistent, incomplete, and never truly satisfactory. Irrigation is essential.

POINT 9. Make no hard and fast rules about colostomy diet.

Comment: One man's meat is another man's poison. Certain foods are reported by patients as both constipating and cathartic (milk, bread, starch foods). Let the patient find out what affects him by gradually adding foods to a basic bland or simple diet. Many patients can eat everything. Let this be known to encourage colostomy patients. Caution that minor upsets along the way can be other things besides the diet. Let the patient reintroduce the item that seemed to upset him at another time.

POINT 10. The irrigation is a planned daily enema.

Comment: The purpose is to clean out the colon once daily in a deliberate, self-regulating manner. Eliminate the hocus-pocus of the procedure by telling the patient exactly what it is. They often harbor the mysterious ideas that wastes would not come out otherwise; that toxins are ridded. Or they feel the water is to soothe the colon or a form of fluid replacement. Call a spade a spade and an enema an enema.

POINT 11. The response by the colon to irrigation is an internal, physiological process and takes a while.

Comment: The filling, stretching and liquifying action of the enema takes time. There is no urgency similar to filling a rectum with fluid. The colon remaining and the colostomy is rather insensitive. No external kneading, pummelling, or pressure on the stomach wall will noticeably alter the process. Position aids only in the completeness of the evacuation; i.e., by dependent drainage.

POINT 12. Colostomy management takes time and patience.

Comment: The total period needed to dilate, irrigate, empty out and cleanse varies from day to day, week to week, but usually averages about an hour. Plan for this. Patients who try to hurry or cut short the procedures end up spilling or cramped (too rapid input of fluid) and uncontrolled.

Summary

Colostomy care assumes added importance because more and more patients will need simple remedies for their minor problems. Education of nursing instructors and physicians responsible for the cases will aid immeasurably. Several suggestions for better understanding and treatment of colostomy difficulties have been presented.

Wisconsin doctors and nurses can help the many hundred colostomy cases in Wisconsin by passing along these suggestions and observations.

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Dissecting Aneurysm of the Left Internal Carotid and Left Middle Cerebral Arteries

Report of a Case

By GORTON RITCHIE, M.D.

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DISSECTING aneurysm of arteries other than the aorta is infrequent enough to warrant reporting a single case. Examination of the possible etiological factors in each case may eventually lead to clearer etiological concepts.

Case Report

The patient, a white boy 17 years old, was admitted to the hospital on Jan. 17, 1955, in a comatose state. On the previous evening he was at a "drinking party," during which he became involved in a fist fight. The amount which he drank and the effect of the drink (presumably beer) cannot be evaluated accurately, but according to witnesses he became boisterous, and one person stated that he "acted like a mad dog," and vomited. He was subsequently taken home by friends, who noted that he was able to climb the stairs to his room and undress himself, retiring at about 2 a.m. He arose at 5:30 a.m., apparently well, and worked (farm work) until 7:30 a.m. At 8 a.m. he was found lying flat on his back (precise location not known) with vomitus around him. He was seen by a physician during the day and a lumbar puncture was performed. The cerebrospinal fluid pressure appeared normal at that time. The fluid was reported to contain 176 mg. of protein per 100 ml., 14 cells per cu. mm., and normal amounts of glucose and nonprotein nitrogen. During the day he was unconscious, responding only slightly to painful stimuli, and he was admitted to the hospital at 8:30 p.m.

Past medical history revealed that in October 1954 he had a somewhat similar episode. He received a severe blow to the "base of his nose" in a football game. That evening at a beer party he had a seizure during which he "lost contact," rolled on the floor for two or three minutes, vomited, and then regained consciousness. No history of aura, convulsion, tongue-biting, or other signs of epilepsy could be elicited. From that time until the present episode he was perfectly well, and never complained of headaches, visual disturbances, vertigo, or other signs of intracranial disorder. He was never known to have any seizure except the two described above, nor could any history of encephalitis or other cerebral lesion be elicited. His general health was considered to be excellent, and he did not appear to be in the habit of drinking excessively.

Physical examination on admission revealed a well-developed, well-nourished young white man in coma. His face was flushed and his breathing stertorous and rapid. His right eyelid drooped somewhat, but his pupils reacted to light and the discs and fundi appeared normal. His blood pressure was 138/70 mm. of mercury.

There was some muscular weakness of the right side of the face and of the right arm and leg. A Babinski reflex was present on the right side and the cremasteric reflex was absent on this side. Reactions on the left side were normal. The spine was nontender, and Kernig's sign was absent.

Laboratory studies revealed that blood counts and urinalysis were within normal limits; cerebrospinal fluid contained 3 lymphocytes and no erythrocytes per cu. mm.; total protein, 39.4 mg. per 100 ml.; chlorides, 116 mEq./L.; glucose, 85 mg. per 100 ml.; Kline and colloidal gold tests revealed no abnormality.

On the afternoon of January 20, he became slightly more responsive than before,

From the Department of Laboratory Medicine, Columbia Hospital, Milwaukee.

Fig. 1—The internal elastica is split, and the inner layer separated from the underlying media on the left (arrow). The resulting space is filled with fibrillar and granular material.

obeying simple commands, but never speaking.

On January 21, arteriography revealed occlusion of the left internal carotid artery above the level of C–1, or the first cervical vertebra. No other abnormality was found in the skull.

Late in the evening of January 21 he became weaker and his pulse became extremely rapid. In the early morning of January 22 he died.

Chief interest in the autopsy studies was related to the pulmonary and intracranial findings.

The right pleural cavity contained about 150 ml. of dark amber fluid, the left cavity none. There were no pleural adhesions. The lungs were the site of considerable edema, chiefly in the dependent parts, and numerous areas of pneumonic consolidation were found on both sides, some portions being hemorrhagic.

The brain weighed 1,470 gm., and there was flattening of the sulci with a definite cerebellar pressure collar. The carotid arteries, which were dissected from below into the neck as far as possible, appeared normal in this region; however, in the distal segment of the intracranial part of the left internal carotid artery, and in the left middle cerebral artery, occlusion was caused by what appeared to be a fresh thrombus. Gross section of the brain after fixation revealed softening in the subcortical region of the left cerebral hemisphere, adjacent to, and to some extent including the basal nuclei. The softened area was about 5 cm. in greatest dimension.

Microscopically the lungs exhibited edema and bronchopneumonia. The brain showed encephalomalacia, with vacuolation and loss of cellular detail in the area described above. The internal carotid artery and the middle cerebral artery on the left side were the site of splitting of the internal elastic lamina, with almost complete collapse of the lumen and varying amounts of blood (at various levels) in the extraluminal space formed by the separation (Fig. 1). Step-sections along the affected arterial segment did not disclose a point of rupture through which the blood might have escaped from the lumen into the extraluminal space.

Discussion

According to Watson,[1] a dissecting aneurysm is a hemorrhagic cleavage between coats, or between the layers of the media of an artery, causing a concentric split along the natural lines of cleavage, usually (but not necessarily) associated with a tear of the intima.

The word "concentric" in this definition is nonessential, and in my opinion is incorrect; in the case here reported the separation was certainly not concentric, but the nature of the lesion nevertheless justifies the name.

Scott, Neuberger and Denst[2] protest mildly against calling such a lesion an aneurysm, since the artery is not increased in diameter; they admit, however, that the term is so firmly established that such a protest is of no avail.

Since reports were reviewed thoroughly in January 1960,[2] no attempt at a review will be made in this article, but only a brief discussion of the etiological factors, especially as they relate to the present case. It might also be said incidentally that the clinical and pathological results of dissecting aneurysms of intracranial arteries are indistinguishable from those caused by thrombosis or embolism.

Up to January 1960 there had been reported 16 cases of dissecting aneurysm occurring in intracranial arteries.[2]

In general, this lesion does not occur in childhood; the age range is ordinarily from late adolescence to the sixth decade. On the other hand, one case has been reported at the age of 6 months. The cases appear to be equally divided between the sexes.

The peculiarities of structure in the intracranial arteries make them particularly susceptible to such lesions. The cerebral arteries have in general a lower proportion of thickness-of-wall to diameter-of-lumen than do other peripheral arteries. They lack an external elastic lamina, and have a thin adventitia. The media itself is somewhat lacking in elastic tissue fibers. Each one of these peculiarities is perhaps unimportant in itself, but taken together they bring about a special local susceptibility to injury from various causes. A slight exaggeration of any one of these factors, difficult or impossible to detect histologically, could be a determining factor in the lack of resistance to stress of any type.

No specific peculiarity of structure was found in the arteries of the patient here described.

Antecedent arterial disease, such as luetic vasculitis and arteriosclerosis, was absent in this patient.

Trauma has been postulated as an immediate cause in several cases. In the present case, the history of trauma is two-fold. Three months before the present illness the patient was injured in a football game, with subsequent temporary changes in consciousness and vomiting, from which he apparently recovered completely. Again, a fist fight the night before admission entered the picture. It is difficult to evaluate the history, since many of the details were obtained at second- or third-hand. From the appearance of the tissues examined, however, it seems clear that the trauma of three months before death can be excluded, as the arterial and cerebral lesions are perfectly compatible with acute disease of five days' duration.

Sudden fluctuation in blood pressure is mentioned by Scott et al, and by Watson, as a precipitating factor. In the present case, an episode is mentioned in which the patient "acted like a mad dog." Exactly what this implies cannot be known with certainty, but one can conjecture with good reason that such an episode was accompanied by a sudden rise in blood pressure. During his course in the hospital, however, the blood pressure was normal.

Finally, Fleming and Park[3] reported two cases in which extensive hemorrhage occurred within the wall of an artery following arteriography. It was postulated that this could be brought about by at least two mechanisms:

1. A dull or barbed needle may tear the artery wall as it pierces it, causing both an opening in the intima and a cleft between or within layers of the wall.
2. Even a sharp needle, having entered the lumen without causing undue damage, may be thrust into the opposite wall, piercing the intima and opening the way to the formation of an extraluminal passage within the arterial wall.

In the present case, the carotid artery at the point of puncture for arteriography was examined thoroughly and found to be free from such injury. The separation had obviously occurred before the angiogram was made, and the lesion was entirely intracranial.

Watson has stated that dissection within the wall of an artery may start with hemorrhage from the vasa vasorum. The findings in the present case afford no evidence as to the presence or absence of this factor.

In conclusion, it seems probable that a combination of trauma and a sudden rise in blood pressure afforded the immediate cause of the lesion described.

Summary

A case of dissecting aneurysm of the left internal carotid and left middle cerebral arteries is reported. Possible etiological factors are considered.

ACKNOWLEDGMENT: I wish to express thanks to Dr. Harry P. Maxwell for permission to utilize the clinical material contained in this report.

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The Cytogenetics of Congenital Anomalies

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DURING THE past five years, many research groups around the world have been carefully examining patients with multiple congenital anomalies for the possibility of chromosomal aberrations. There has been a remarkable surge of interest in this type of investigation for a number of reasons. First, methods have been developed during this period which permit more accurate analysis of the chromosomal complement of the mammalian cell. Prior to this time by necessity, studies were confined to autopsy or biopsy material, especially of rapidly-dividing testicular tissue. Due to the technical difficulties encountered in these studies, few investigators dared or cared to pursue the human chromosome. With the advent of applicable tissue culture techniques and a few related improvements in methodology, it became possible to collect material from any patient and to prepare slides from this material permitting many cells to be captured in mitosis. The second reason for the renewed interest in human chromosomology was the unexpected observation that a few well-known clinical syndromes were associated with either the presence of an additional chromosome or the absence of one chromosome from the normal human complement of 46. When one considers that in a disease such as sickle cell anemia a single gene mutation results in severe biochemical and structural changes, the absence or presence of an additional chromosome would be expected to be lethal. The fact that certain major alterations in the nuclear constitution are not necessarily incompatible with life has encouraged many investigators to enter this previously forbidden research field.

A third reason for renewed interest in human cytogenetics is that changes in the actual number of sex chromosomes were reported in several patients with endocrine disorders. Work in this area was aided by the previous demonstration of the sex chromatin body in the resting nucleus by Barr and Bertram.[1] Using sex chromatin determinations plus chromosome analysis, endocrinologists and gynecologists have been able to assess problems of intersex, sterility, and hormonal interrelationships more intelligently than before. In 1959, two common clinical endocrinological syndromes were found to be caused by variations in the number of sex chromosomes. In XO gonadal dysgenesis, i.e. Turner's syndrome, there is an absence of one sex chromosome. This syndrome is characterized by shortness of stature, lack of differentiation of the gonads with an undeveloped female reproductive system, and failure of development of secondary sex characteristics at puberty. Other anomalies are frequent, including webbing of the neck and abnormalities of the cardiovascular system. In chromatin-positive Klinefelter's syndrome, XXY, there is an extra sex chromosome. These patients have unusually long legs and eunuchoid traits, with small testes showing fibrosis and hyalinization of the seminiferous tubules. They are often mentally defective. Less common situations have been found more recently in which the chromosome constitutions have included XXX, XXYY, XXXX, and XXXY. Other unusual mosaic patterns have been described in rare cases. The problems encountered in sex determination, in gonadal differentiation, etc., although interesting, are outside the scope of this paper.

A further stimulus for concern with chromosomal constitution arises in the field of congenital anomalies in general. Here the question presents itself as to the number and types of congenital malformations which may have a chromosomal basis. Probably the commonest example of a condition in which a multiplicity of anomalies are seen is mongolism. In 1959, a French research group discovered that in mongoloid patients an extra chromosome is present in each nucleus.[2] This finding was quickly confirmed by several other cytologists. The extra chromosome in each case was the same; it could be identified as one of the smallest autosomes. The

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autosomes are the 22 pairs of chromosomes which, together with the two sex chromosomes, account for the total number of 46 in each human diploid cell. Mongoloid patients, therefore, have 47 chromosomes, with one autosome being present in triplicate rather than as a pair, a situation known as "trisomy" for that autosome. At the University of Wisconsin Medical School, efforts were started in early 1959 by an inter-departmental team consisting of Drs. K. Patau, E. Therman, D. Smith, R. DeMars, the author, and others to study children with multiple congenital anomalies for the possibility of chromosomal aberrations. The results of these investigations are reviewed here.

Methods of Study

All patients suspected of having abnormalities in their chromosomal complement must be subjected to thorough physical examinations, and detailed personal and family histories must be elicited. The finding of even minor physical defects, such as abnormal contour of the ears, foot and hand malformations, unusual shape of the skull, are of utmost significance, as illustrated below. Such poorly-defined features as failure to thrive and decreased muscle tonus may also be part of certain definite syndromes. From the historical aspect, paternal and maternal age and health are naturally very important questions, particularly as related to the pregnancy of the patient under observation. Abnormalities in the immediate family and in other relatives becomes pertinent information in an integrated clinical-cytological approach to congenital disease. Buccal smears for sex determination, detailed photographs of the patient, and foot and hand prints give additional information in many cases and are necessary for documentation. X-rays, psychomotor testing, muscle charts, and a variety of laboratory studies are often required for a complete patient examination.

After the subjects have been investigated thoroughly as to their family background and physical and laboratory changes, specimens are obtained for chromosome analysis. At the outset of this project, bone marrow aspirates were employed as the source of this material, since marrow is one of the few sources of actively proliferating cells. Due to the vagaries of the marrow puncture, however, this method was later practically abandoned for skin and organ biopsy and peripheral blood cell cultures. The latter procedures, while differing in certain technical aspects, generally provide an adequate number of dividing cells if fresh material can be obtained. After cell cultures have become established in the incubator, colchicine is added to the growth medium for a short period. This drug causes mitosis to halt in metaphase, with chromosomes scattered throughout the nucleus. Following colchicine treatment, cultures are placed in a hypotonic solution which causes cell nuclei to swell and further disperses the chromosomes. Preparations are then fixed and stained, and slides are observed for satisfactory mitotic figures. On these slide preparations, the observer must search for mitotic figures having chromosomes in the horizontal plane, with little overlapping of chromosomal arms and with no artefactual changes. A number of clear mitotic plates must be recorded on each patient, and the results agreed upon by two or more cytologists. The preparation, observation, and interpretation of these slides requires a great deal of skill and experience.

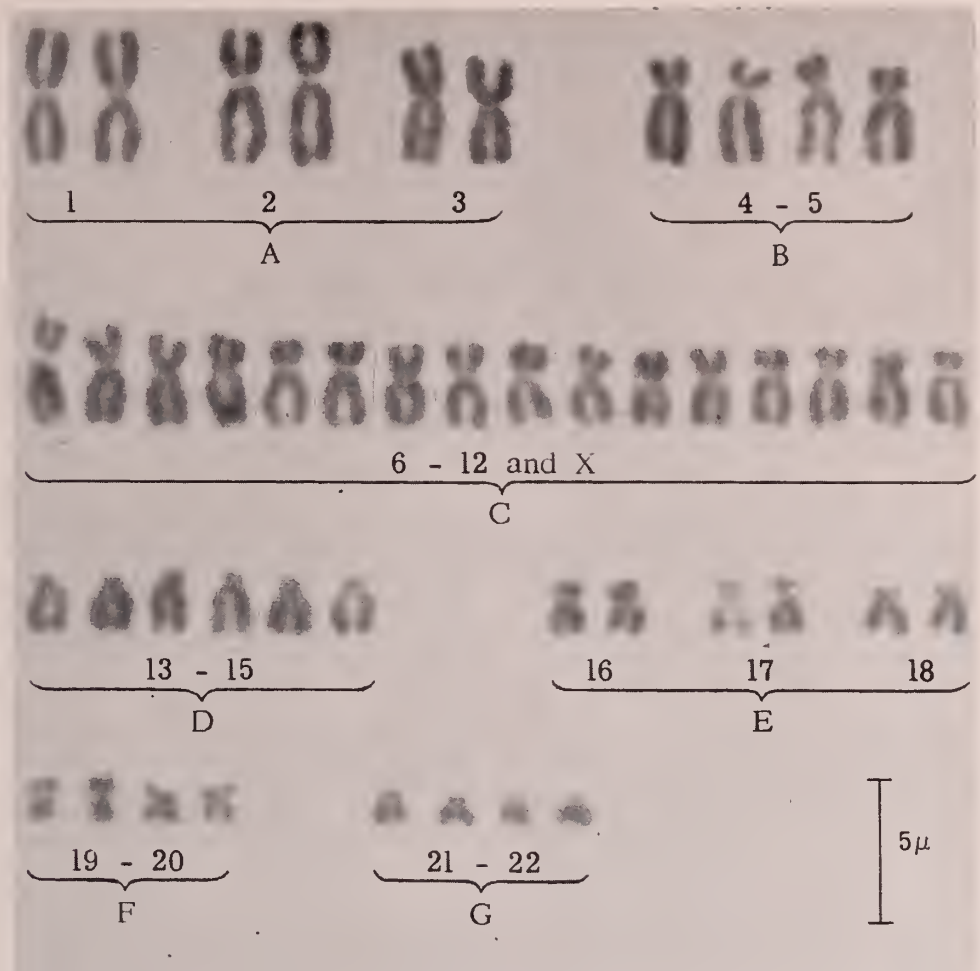
Chromosomal analysis is a tedious and time-consuming procedure, so that cytogenetic studies remain a research rather than a diagnostic exercise. After recording them by sketch or by photomicrograph, chromosomes must be identified as to their proper group. For purposes of analysis, chromosomes are classified according to their size and the position of their primary constriction or centromere. Using these criteria, the 22 pairs of autosomes plus the X and Y chromosomes can be placed into 7 groups, A through G (Table 1).

TABLE 1—*Human Chromosome Idiogram*

Group	Size and Centromere Location	Chromosome Pairs
A	Largest, median	1 through 3
B	Large, submedian	4 and 5
C	Medium, submedian	6 through 12 plus X
D	Medium, subterminal	13 through 15
E	Short, median and submedian	16 through 18
F	Short, median	19 and 20
G	Very short, subterminal	21 and 22 plus Y

Trisomy Syndromes

In mongolism, as was mentioned previously, an extra G chromosome is present in each cell, giving rise to the abnormal complement of 47 chromosomes. The mechanism which is thought to be responsible for this abnormality and which probably occurs in the formation of the ova or sperm is called non-disjunction. As the name implies, non-



Sex	Number of C Chromosomes			Number of G Chromosomes		
	Autosomes	X	Total	Autosomes	Y	Total
Female (as above)	14	2	16	4	–	4
Male	14	1	15	4	1	5

Fig. 1—The 46 human chromosomes arranged in groups of decreasing size.

disjunction refers to the failure of separation of paired chromosomes so that one daughter cell gets both members of the pair and one cell gets none. Fertilization of an ovum which contains two 21 chromosomes instead of one (total number, 24) would give rise to a zygote with a total of 47 chromosomes.

When one considers that the presence of even a small amount of extra chromosomal material as represented by a mongolism chromosome in triplicate results in multiple system anomalies, the likelihood of finding trisomy for any of the larger chromosomes seems remote. Surprisingly enough, two distinct syndromes have been discovered, one due to an extra D chromosome (called the D_1 trisomy syndrome) and one due to an extra E chromosome (the number 18 trisomy syndrome).[3,4,5,6,7] These are the only other two autosomal trisomy syndromes which have been confirmed to date. While not nearly as common as mongolism, these syndromes have certain characteristic features so that since first being described, additional cases have been properly recognized clinically prior to chromosomal analysis. The two conditions are thought to arise, as does mongolism, by a process of meiotic non-disjunction. Some of the physical features which

TABLE 2—*Comparison of Two Autosomal Trisomy Syndromes*

D_1 trisomy syndrome 1 male, 3 female infants (3 dead) (maternal age: 26, 36, 34, 43)		No. 18 trisomy syndrome 2 male, 5 female infants (7 dead) (maternal age: 21, 30, 37, 39, 43, 46, 46)	
Anomaly	Frequency	Anomaly	Frequency
Apparent mental retardation	4/4	Apparent mental retardation	7/7
Seizures	4/4	Hypertonicity (moderate)	7/7
Apparent deafness	4/4	Failure to thrive	7/7
Eye defect (from severe microphthalmia to colobomata)	4/4	Flexion of fingers with index finger overlapping third	7/7
Hyperconvex finger nails	4/4	Ears low set and malformed	7/7
Cleft palate	4/4	Small mandible	5/5
Hare lip	3/4	Meckel's diverticulum	5/5
Haemangiomata	3/4	Dorsiflexion of big toes	5/5
Horizontal palmar creases	3/4	Heterotopic pancreatic tissue	4/4
Interventricular septal defect	3/4	Interventricular septal defect	6/7
Dextrorotation of heart	2/4	Patent ductus arteriosus	5/6
Retroflexibility of thumbs	2/4	Inguinal and/or umbilical hernia	5/7
Flexion of fingers and hands	2/4	Prominent occiput	5/7
Polydactyly of feet	2/4	Renal anomaly	4/7
Rocker-bottom feet	2/4	Eventration of diaphragm	3/7

characterize these two syndromes are listed in Table 2.[6]

Several facets of the autosomal trisomy syndromes deserve comment. First, there are certain features of each syndrome which have been found in all cases studied thus far. For instance in the D_1 trisomic patients, mental retardation, seizures, deafness, eye defects, hyperconvex fingernails, and cleft palate are regular occurrences. Other defects are present in the majority of cases. Still other malformations are found less commonly, some only in isolated cases. The same can be said for the No. 18 trisomy syndrome. Mental retardation, small mandible, hypertonicity, low set ears, and failure to thrive have been found in all cases. This frequency does not exclude the possibility that in the future, isolated cases may occur in which all these features are not present. As an analogy there are many atypical mongoloids who do not display the horizontal palmar crease or the flat occiput so commonly associated with this condition.

Another important observation is that of the 11 trisomic patients summarized here, 10 are dead and only one is alive, at age 2½ years. It is obvious that these patients do not survive as long as mongoloids. Also D_1 trisomy and 18 trisomy are much less common than mongolism, which occurs once in 700 births. One possible explanation for their rare occurrence is suggested by these mortality figures. The two syndromes may be generally lethal conditions, with only rare cases surviving into infancy. Another possible explanation for their lower frequency is that larger chromosomes are probably subject to less non-disjunction. Certain points of similarity are noted. In both syndromes, the maternal age is generally quite high, as is true in mongolism. Also in all three autosomal syndromes, multiple systems are involved, and most patients in all categories appear to have mental retardation as an outstanding feature, as well as some sort of heart involvement.

Since Table 2 was compiled, we have found additional D_1 and 18 trisomic patients, and more have been reported from other laboratories. In addition, we have studied a large number of patients in the past two years who have manifested various combinations of the anomalies found in either syndrome but who have 46 apparently normal chromosomes. These negative cytological findings raise an interesting question as to the etiologic mechanism in this large group of related congenital malformations. Possibly multiple anomalies may have developed in these cytologically normal patients as a result of gene mutation or damage secondary to radiation, chemical exposure, virus infection, or other mechanisms not completely understood. However some of these cases may be a result of the presence in triplicate of only a segment of a chromosome, as described below.

Partial Trisomy Syndromes

The likelihood of discovering additional trisomy syndromes such as the D_1 and 18 syndromes appears remote, since thousands of patients with congenital anomalies have already been studied in many research centers throughout the world. To date no other autosomal trisomy syndrome aside from the D_1, 18, and G syndromes have been established. One might think that future discoveries in the field of human cytogenetics and congenital malformations would be slow in coming. Such has not been the case. In fact, a sizable number of chromosomal aberrations have been described in the past two years. Certain of these aberrations arise by mech-

anisms which often leave the basic chromosome number unchanged. Therefore to uncover these abnormalities, merely counting the chromosomes will not suffice. What is required is a detailed analysis of the component segments of each chromosome. Obviously this type of investigation requires greater skill and diligence.

Various intrinsic and extrinsic factors can adversely affect the orderly process of cell division so that one or more chromosomes are altered. As a result of breakage of a chromosome, a deficiency or deletion of a portion of a chromosome may result. The antithesis of a deletion is a duplication of a fragment, where a portion of a chromosome is present either as a separate piece or is translocated onto or inserted into another chromosome. A reciprocal translocation occurs when portions of two chromosomes are exchanged. Inversion refers to the rotation of a chromosomal segment 180 degrees. Any of these rearrangements may result in serious consequences, yet the chromosome number may be unchanged. The one rearrangement most likely to be detected cytologically is a translocation where an additional segment is added to another chromosome arm. Just as in the 18 trisomy syndrome where one chromosome is present in triplicate, the presence of an additional segment would necessarily mean that the segment was present in triplicate. This phenomenon has been referred to as "partial trisomy."

One example of partial trisomy was found in a patient with Sturge–Weber's disease.[8] This disease is characterized by mental retardation and seizures, with numerous cutaneous and intracranial hemangiomas. Intracranial calcification is visible by x-ray. Previously there had been a report of a Sturge–Weber patient having 47 chromosomes, the extra chromosome being in the G group.[9] In our patient, a chromosomal fragment of similar size was translocated to the short arm of a D chromosome. In 16 additional cases of Sturge–Weber's disease reported by other observers and by our group, no chromosomal abnormalities were seen. Since the chromosome segment in question is small, a translocation to a longer arm could well escape detection, thus accounting for the negative cytologic findings in these patients. In the two cases with chromosomal abnormality, it seems clear that the extra chromosomal material is responsible for the syndrome. It will be interesting to see in the future, how many of the Sturge–Weber translocations can be cytologically detected.

A second partial trisomy syndrome was described recently.[10] The partial trisomy was found in a rare disease known as the "oral-facial-digital syndrome," or OFD syndrome. Patients with this condition have cleft palate, eyes set widely apart, pseudocleft of the upper lip, oral mucous membrane webbing, varying finger lengths with lateral and medial deviation of the digits, and other less common anomalies. In two cases of the OFD syndrome, a girl and her mother, an inner segment of a C chromosome was found to be inserted into chromosome 1. One of the C group, called C′, can sometimes be identified by a secondary constriction. In the OFD cases, it is an inner segment of this C′ chromosome which is present in triplicate. The other chromosome 1, the two chromosomes C′, and the remainder of the 46 chromosomes appear normal. Four other OFD patients displayed no chromosomal abnormality. As in the case of the cytologically-negative Sturge–Weber patients, the extra segment could easily escape microscopic detection. Whereas the trisomic segment in the Sturge–Weber cases may have resulted from reciprocal translocations requiring two chromosome breaks, when an insertion is postulated, at least three breaks are involved. The OFD syndrome is the first condition in which a recognizable insertion has been found in man. This syndrome is also interesting because of its familial incidence, and the fact that it occurs only in females although the partial trisomy is for a segment of an autosome. Furthermore, all cases have anomalies of the oral cavity, but involvement of the facial and digital areas suggests definite familial patterns. Perhaps the segments involved in different individuals are slightly different in length. Family studies in the future might permit actual mapping of trisomy loci for the inner segment of the chromosome C′.

Future Developments

The above syndromes with their many unanswered questions suggest several worthwhile avenues of research. One area of investigation being actively pursued is the study of additional patients displaying features of these already-established trisomy and partial trisomy syndromes. The aim here is to collect a large number of cases,

including family studies of each syndrome. A comparison of these cases should then show whether the anomalies can be arranged in a linear sequence, with certain anomalies always being consecutively arranged. A mapping of trisomy loci by this method may be possible for the inner portion of the C′, the D_1, the 18, and the G chromosomes.

Another avenue of research might be called a population type of study. This type of investigation is suggested by the familial incidence of the OFD syndrome and the reported cases of familial mongolism. Although no OFD carriers have yet been encountered, there are several reports of chromosomal abnormalities in relatives of mongoloid patients, who are themselves healthy individuals.[11] We have also seen such cases. Other interesting family studies have been reported. Moorhead et al. have investigated a family in which an autosomal translocation is present with a total complement of 45 chromosomes in a mother and in four of her six children.[12] The four children have varying degrees of mental retardation, with a very striking failure of speech development. These and other family studies raise the interesting possibility of chromosomal abnormalities occurring in a large number of different conditions and even in phenotypically normal individuals. One approach to this fascinating question is to study congenital anomalies in newborn infants. Dr. D. Smith and his associates have been studying newborn infants at a hospital in Madison, to determine the frequency of major and minor anomalies in this population group and to determine factors which might influence their occurrence. Special attention has been given to the detection of minor anomalies, which may be of considerable diagnostic importance when multiple. An attempt is being made to evaluate the absolute and relative incidence of known chromosomal abnormalities of sex chromosomes (XXY Klinefelter's syndrome, XO gonadal dysgenesis, and the triple-X syndrome) and of the autosomes (mongolism, the 18 trisomy syndrome, and the D_1 trisomy syndrome).

Another survey is being made with the cooperation of Madison physicians to determine the number of chromosomal aberrations found in spontaneous abortions. Factors of maternal environment excluded, the majority of spontaneous abortions have been casually attributed to a "blighted ovum." Just what percentage of cases of spontaneous abortion will show abnormal chromosomes remains to be seen. Undoubtedly a large array of deletions, translocations, and trisomies will be found.

In the future, our group at Wisconsin and investigators elsewhere will continue to search for new cases of insertions, mosaics, and translocations, in the hope that additional information will give us insight into the mechanisms leading to congenital malformations. Large population studies among mentally retarded patients will undoubtedly be started some day to determine the frequency of chromosomal abnormalities in this group and its significance. The mode of inheritance of chromosomal defects certainly deserves additional attention, and more thorough family studies will soon be carried out with this goal in mind. Today, genetic counseling of parents having children with multiple anomalies is possible to a limited extent. When we know more about the mechanisms of chromosomal aberrations, more thorough and realistic counseling will be possible.

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Rabies—Development of Diagnostic Facilities in Wisconsin and Report of a Human Case

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IN 1914 when Doctor William D. Stovall arrived in Madison, Wisconsin, to take charge of the State Laboratory of Hygiene (then called State Hygienic Laboratory), he found among the many activities of this laboratory the rabies problem. The establishment of Pasteur Institutes had been spreading over the United States from the original Pasteur Institute established in Paris in 1886. In 1890 the New York City Pasteur Institute was founded, the first in this country. The Chicago Pasteur Institute was established in the same year, followed by institutes in Baltimore, Richmond, Atlanta and others. In 1909, through activities of Drs. C. A. Harper and M. P. Ravenel, Wisconsin founded a Pasteur Institute, in the State Hygienic Laboratory then located on fourth floor of South Hall at the University of Wisconsin, for administering the Pasteur treatment. At this Institute from November 14, 1909 to 1911, there were given 126 courses of treatment by Dr. F. F. Bowman, then in charge of the work as a part of his duties with the State Board of Health. These treatments were continued for about five years after Doctor Stovall took charge of the laboratory. Material for these treatments was procured from the Hygienic Laboratory in Washington.

Up until 1903 when Adelchi Negri discovered inclusion bodies which now bear his name, clinical diagnosis by veterinarians had been the surest immediate method of rabies diagnosis. Some laboratories employed histologic sections of various parts of the neural anatomy to supplement the clinical findings. Rabbit inoculation sometimes followed. Shortly after Negri's work most laboratories made stained preparations of the brains of animals dying of suspected rabies to search for these Negri bodies as pathognomonic entities.

The demonstration of Negri bodies in sections using the histologic technic of fixation by alcohol, clearing in aniline oil, followed by embedding in paraffin and sectioning was soon replaced by Doctor Stovall using the rapid acetone fixation followed by paraffin embedding. He also used the ethyl eosin-methylene blue technic on both smears and sections instead of the usual hematoxylin-eosin method used in general histologic work. Stains by Grubler from Germany then were readily available, but World War I gradually made these stains unavailable. The ingenuity of the American chemistry industry soon produced dyes formerly purchased in Germany. In 1925, Doctor Stovall was one of a group of histologists and pathologists who cooperated with the Biological Stain Commission in the publication of the First Edition of the book known as Biological Stains. Because of his interest in rabies and the stains used to demonstrate Negri bodies, Doctor Stovall was sent specimens of ethyl eosin for testing from every batch produced before the product was given a certification number by the Commission. Doctor Stovall has fostered research on rabies diagnosis from his early years in the laboratory. In 1940, Stovall and Black[1] published work on the effect of pH on the eosin-methylene blue staining method and in 1941 with Pessin[2] he published problems in laboratory diagnosis of rabies in which they gave data on the mouse inoculation method developed by Webster and Dawson[3] and later by Leach.[4] Trenary[5] summarized the results of the technic followed in Doctor Stovall's laboratory during the years 1940 to 1955 on over 2,000 examinations.

From the University of Wisconsin Medical School, Department of Pathology and State Laboratory of Hygiene.

Two human brains were examined by this technic, one from Janesville, Wisconsin, and one from a case which reached Wisconsin General Hospital from Baraboo, Wisconsin. The brain from the latter case, which was undiagnosed, was sent to Doctor Stovall's laboratory by Doctor Hartmann who gives the following account of the case.

Report of Case

An 11-year-old boy was admitted to a local hospital for fever and irrational behavior. One week earlier malaise and nausea started and was followed by irritability and jerking movements of the extremities. The night before he was transferred to University Hospitals, slight dysphagia was noted and there was slight epistaxis twice.

On admission here the temperature was 104.8 F., blood pressure 100/50, pulse 100 and respiration 20. The patient was restless and hallucinated. A few abrasions were seen on the face, hands and legs and some rashes on the back. The pupils were equal, but smaller than usual and reacted slightly to light. The child could swallow. There was slight resistance to flexion of the neck. The patient had difficulties in raising himself up to sitting position and was unsteady when raised up. A lumbar puncture on the day of admission revealed clear fluid, 262 cells of which 95% were lymphocytes. Protein was 65 mg. and gold sol was negative.

The jerking movements persisted even in sleep. He became lethargic, and the pupils became sluggish. On the fourth hospital day he was noted to have occasional Cheyne-Stokes respiration, urinary incontinence, edematous eyelids, neck rigidity and Kernig sign was positive. He died on the evening of the following day.

The general autopsy was essentially negative. The brain appeared to be swollen and weighed 1,350 grams. The leptomeninges and sections through the brain showed considerable congestion of gray and white matter.

Microscopically, lesions were noted throughout the central nervous system. The gray matter of the spinal cord revealed perivascular infiltration, loss of ganglion cells, Nissl degeneration, shrinkage of ganglion cells, ghost-like necrosis, hyperemia and diffuse glial proliferation. The cerebellum showed most of the same changes and in addition within the cytoplasm of a few Purkinje cells small oval-shaped deep eosinophilic inclusions were seen. In the medulla the inflammation was most extensive and was not limited to the gray matter. The olives and the cranial nerve nuclei were involved by exudation, glial proliferation and nerve cell degeneration. Eosinophilic cytoplasmic inclusions were seen in many of the nerve cells. In the midbrain, nucleus ruber, thalamus and substantia nigra were all involved. Most prominent was the inflammation in the claustrum and globus pallidus. Also involved were subcortical white matter and cerebral cortex. Sections through the Ammon's horn showed the nerve cells to have a homogeneous brick red cytoplasm. No inclusions were seen here.

Small portions of Ammon's horn and cerebral cortex were excised from the fresh brain and submitted for examination to the State Laboratory of Hygiene. Paraffin sections were examined for Negri bodies. Mice were inoculated and after 10 days the mice showed definite signs of cerebral involvement. The Negri bodies (intra cytoplasmic inclusion bodies) were identified with the Stovall Black stain.[1]

Comment

While formerly the main vector animal was the dog, many other animals have been found to be infested with the rabies virus. In Wisconsin 80% of the skunks examined show Negri bodies. Since 1957, several insectivorous bats have been found to have rabies. Last year a patient died in this hospital after a bite from a rabid bat. Today it seems pertinent to conclude that rabies remains a potential threat to human health and a diagnostic problem to the practicing physician.

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Mesenchymal Metabolism and Hyaluronic Acid Synthesis

By CHARLES H. ALTSHULER, M. D., and JOHN BARETA, M. D.

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AN IMPORTANT intermediate step in the process of serious inflammation is the formation of acid mucopolysaccharides in the ground substance of the connective tissues.[1,2] Since it is believed that these polysaccharides participate in the formation of amyloid, fibrinoid, and hyaline, the cellular and tissue factors involved in the synthesis of these materials are of great interest to students of disease.

In recent years, several exciting discoveries have implicated the uridine nucleotides as important intermediate metabolites in the formation of these polysaccharides. This development began with the researches of Roseman et al.[3] and Topper and Lipton[4] who showed that glucose is incorporated directly, i.e., without prior scission, into the hexosamine and glucuronic acid moieties of hyaluronic acid in Group A Streptococci. Leloir and co-workers,[5,6,7] then, in a series of elegant investigations, demonstrated the coenzymatic role of some of the uridine nucleotides in the synthesis of several complex carbohydrates including trehalose, sucrose and glycogen. Others found that chitin and cellulose are also probably synthesized by reactions involving these nucleotides.

Following these developments, the work of Glaser and Brown[8] indicated that uridine nucleotides were involved in hyaluronic acid production in the Rous sarcoma; and Markovitz, Cifonelli and Dorfman[9] demonstrated that they also participate in the synthesis of the capsular polysaccharide of the Group A Streptococci.

It was our purpose in the study described here to determine whether the pertinent nucleotides and synthetases also occurred in mammalian tissues. Using either C^{14}-UDPGA or H^3-UDPNAG* as markers in incubation media similar to that of Markovitz et al., we were able to show that cell-free extracts from several human tissues can synthesize hyaluronic acid.

After incubation, cold hyaluronic acid (isolated from the source of synthetase studied) was added as carrier and the deproteinized reaction mixtures were subjected to a separative procedure on columns of dextran gel (40 x 3 cm. Sephadex G–50).[10] Differences in elution patterns and specific activity were demonstrated between radioactive hyaluronic acid derived from synovial reactants and that from Rous sarcoma or encapsulated Group C Streptococci. Synovial hyaluronic acid demonstrated greater polydispersity and a higher specific activity in the lower molecular weight fractions.

When neutralized perchloric acid extracts from several hyaluronic acid synthesizing systems were subjected to chromatography on 1 x 15 cm. Dowex–1 x 4 chloride columns, using a modification of the concave gradient elution of Pontis and Blumson,[11] characteristic nucleotide patterns were obtained. After the tubes containing the ultraviolet absorbing peaks were pooled, neutralized, desalted and purified by paper chromatography, UDPGA and UDPNAG could be identified by proper chemical and enzymatic techniques.

Summary

The findings described here are compatible with the concept that the uridine nucleotides are involved in the synthesis of hyaluronic acid in human tissues.

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* UDPGA—uridine diphosphate glucuronic acid. UDPNAG—uridine diphosphate N-acetyl glucosamine.

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Production of Abdominal Hernias in Suckling Rats with Sulfated Hyaluronic Acid

By LEONARD MERKOW, Ph. D., and JOSEPH J. LALICH, M. D.

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SEVERAL REPORTS indicate that hormones, hormone-secreting tissues, or copper-deficient diets are capable of producing experimental hernias. Transplantation of immature testes or testicular tumors into the lower abdominal region of certain inbred strains of female mice also produces inguinal hernias.[1] Male and female mice administered estradiol and testosterone respectively for six weeks, develop scrotal or inguinal hernias.[2] Abdominal hernias and subcutaneous hemorrhages are characteristic of newborn rats delivered by mothers fed copper-deficient diets.[3] Injections of sulfated hyaluronic acid into rabbits' eyes produce a liquefactive depolymerization of the vitreous humor.[4] Because of the demonstrated depolymerizing property on acid mucopolysaccharides, it seemed desirable to determine if this compound could facilitate hernia formation. In our study, repeated intraperitoneal administration of sulfated hyaluronic acid into rats produced degeneration of dermal components and abdominal hernia formation at the site of local injection.

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This investigation, by Doctor Merkow, was supported in part by a Public Health Service Post-Sophomore Research Fellowship, PX–340–4, from the Division of General Medical Sciences, Public Health Service.

* Synthesized and generously supplied by G. D. Searle & Company, Chicago, Illinois.

Materials and Methods

Ten-to-twelve-day-old suckling rats were given an intraperitoneal injection of 0.5, 1.0 or 2.0 mg. per day of buffered sulfated hyaluronic acid* daily for 1 to 90 days. These 21 animals were allowed to nurse until weanling age was attained and then were given Purina Chow pellets and water ad libitum. Eleven control rats (1 to 4 per litter) were injected intraperitoneally with 0.9% normal saline. At autopsy abdominal hair was shaved and sections of the abdominal wall extending from the epithelium through the peritoneum encompassing both the distended herniated region and adjacent normal tissue were removed and placed in 10% formaldehyde solution (Formalin). Visceral organs were also sectioned for microscopic examination.

Paraffin blocks were cut at 6μ, stained with hematoxylin and eosin or toluidine blue, and examined microscopically. Initial and autopsy weights were recorded.

Results

Ten-day-old rats receiving 1 to 2 mg. per day of sulfated hyaluronic acid developed a transitory abdominal wall hemorrhage during the first 3 or 4 days of injections. Animals weighing less than 10 gm. usually did not survive the hemorrhagic infiltration of the abdominal wall, from the xiphisternum to the pubic symphysis. Suckling rats surviving the initial phase of hemorrhage usually grew to adulthood. Injections of 0.5 mg. per day proved less toxic to suckling rats and usually produced only minimal hemorrhage. Subsequent abdominal hernia formation developed in these animals after 10 to 14 days. Once abdominal hernias developed they persisted without further progression or regression even after injections were terminated. Four such adult animals autopsied following death were found to have intestinal obstruction secondary to volvulus of the small intestine. Microscopic examination of the dilated abdominal wall demonstrated atrophy, fragmentation or necrosis of striated muscle and decreased interstitial connective tissue. Neither leukocytic infiltration nor exudation was seen in the abdominal wall. Sections from the site of herniation stained with toluidine blue revealed an increase in metachromasia. Control animals injected intraperitoneally with 0.9% normal saline did not develop hernias at the site of inoculation nor exhibit abnormal microscopic changes.

Fig. 1—Control and test rat received daily injections of 0.9% normal saline and 1 mg. of buffered sulfated hyaluronic acid respectively for 90 days. The test animal developed a large abdominal hernia.

Discussion

Sulfated hyaluronic acid is somewhat similar to heparin in both structure and physical properties. The former has three rather than five sulfate groups. Both exhibit lipemia clearing, anticoagulant, antihyaluronidase and antifibroblast growth activity.[5,6] Both antihyaluronidase activity and meta-

TABLE 1—*Response of Immature Rats To Daily Intraperitoneal Injections of Sulfated Hyaluronic Acid*

	No. of Animals	Sex	Average Initial Wt. of Animals (gm.)	Mg. of Buffered Sulfated Hyaluronic Acid per Day I. P.	Duration	Average Wt. Gains per Day	Abdominal Hernias	Hemorrhage
11 Control, 21 Test	2	Mixed	22.0	Saline	90	2.8	0	0
	3	F	20.0	0.5	90	2.2	+	0
	2	M	20.0	0.5	70–90*	3.3	+	0
	2	Mixed	14.0	Saline	36	3.3	0	0
	3	Mixed	13.0	1.0	36	2.6	+	+
	1	M	18.0	Saline	51	3.5	0	0
	3	M	14.0	1.0	51*	3.0	+	+
	6	Mixed	10.5	Saline	8	2.5	0	0
	6	Mixed	11.2	1.0	1–8	1.3	0	+
	4	Mixed	9.3	2.0	1–8	1.6	0	+

+ Signifies that all animals in that assay manifested pathologic changes.
* One or more animals died of intestinal obstruction secondary to volvulus formation within the abdominal hernia.

chromasia depend on the presence of anionic polyelectrolytes.[7] However, liquefaction of vitreous, as well as the changes noted in the abdominal musculature and interstitial connective tissue in our experiment, suggests that sulfated hyaluronic acid may act like a hyaluronidase. The "spreading factor" of Duran–Reynals converts the gel state of hyaluronic acid to that of a sol, thus breaking down a natural barrier in the ground substance.[8] Similarly, vitreous humor is liquefied by the action of sulfated hyaluronic acid. It would appear that chemical changes induced in connective tissue of the anterior abdominal wall by injections of sulfated hyaluronic acid in some manner aid the intra-abdominal pressure to produce abdominal hernias. Since experimental studies with hyaluronic acid injections do not report hernias, it seems likely that sulfation of this compound endows it with this property. Tissue metachromasia usually connotes either depolymerization or increased synthesis of acid mucopolysaccharides. In this study, the significance of metachromasia remains doubtful since it can be due either to the presence of sulfated hyaluronic acid or altered mucopolysaccharides at this site. Normally hyaluronic acid occurs in the body only in a nonsulfated form. This experiment illustrates that sulfation of hyaluronic acid is associated with the acquisition of unusual biological properties. Results observed in this study, therefore, support the suggestion of Talman and Harris, that slight chemical modifications such as sulfation could produce disease.[9]

Summary

Sulfated hyaluronic acid was injected into 10-day-old suckling rats daily for 1 to 90 days. Animals frequently did not survive the initial anterior abdominal wall hemorrhage which resulted when 1 to 2 mg. per day of this compound were administered. Surviving rats and animals receiving 0.5 mg. per day developed persistent abdominal hernias after two weeks. Similarities between sulfated hyaluronic acid, heparin, and hyaluronidase have been presented.

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NEW SUCCESSES bring new problems. In one era prevention of disease brings success at which some marvel, only to usher in another which creates a state of quandary. But we dare not let them stop; prevention must progress while we search for a solution of the problem which has thus been created. The purpose of all humane effort is the promotion of the welfare of mankind and the preservation of the dignity of each individual without which all is lost.

—*W. D. Stovall, M.D.*

Sudden Unexpected Death in Infancy
A Disease of Theories

By J. D. COLLINS, M. D., and P. G. PIPER, M. D.

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A quest for the pathogenesis, whether it be an organism, chemical complex, or abnormal cell, has always been an attribute of Dr. W. D. Stovall. As one of my teachers in the field of pathology, he always provided the right catalyst to help solve any problem relative to a disease state. Because of his interest to all related problems of epidemiology and because his work covers such a facet of investigative knowledge, I hereby dedicate this publication to my teacher, friend, and former director of the State Laboratory of Hygiene.

THE PATHOGENESIS of sudden unexpected death in infancy is subject of much investigation and speculation. It has been estimated[1] that this syndrome could include 11,500 infants or one-tenth of the total national infant mortality. Recently the medical profession has been made more aware of the magnitude of this problem. The cause of death of 25 to 40 per cent[2] of infants who die after the neonatal period but before two years of age can not be found at autopsy.

The deaths can be placed in three groups: (1) infections, (2) congenital anomalies, and (3) those for which no demonstrable cause can be found. This last group will be discussed in this paper.

During the first part of the century, smothering was considered a common cause of death. The last person to report on it at any length was Abramson[3] in 1944. A few proponents still support this concept, but on the basis of more complete autopsies and the studies of Woolley,[4] who showed that all efforts to produce anoxemia and hypercapnia in infants by bed clothes were unsuccessful, this theory has been discarded. Weaker infants might possibly succumb by this mechanism, but the peak age incidence of unexplained sudden death is at three months. If smothering were the cause, we would expect the incidence to be higher in younger infants.

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Status thymicolymphaticus has been incriminated intermittently for many years. The last person to express his support of this concept was Carr[5] in 1945. He reviewed 500 infant autopsies and concluded that an enlarged thymus could cause tracheal compression. Later investigators calculated the thymus and adrenal size and postulated adrenal hypoplasia as a mechanism. Selye[6] proposed that adrenal insufficiency is the prime factor and the thymus can be disregarded. This latter theory has not been confirmed by post-mortem examination, since autopsies revealed smaller adrenals in the children who suffered violent death than in those who were found dead.

Aspiration has often been given as a cause of death because in many instances these children are found with face, mouth and adjoining bedding covered with vomitus. However, several investigators[7,8] believed this to be an agonal phenomenon and not the primary cause of death.

Respiratory infection,[1,8–11] viral or bacterial, has been proposed more often than any other cause, probably on the basis of finding an organism at autopsy. In many instances where organisms have been isolated, the changes have been minimal and one wonders why so many are so affected by so little.

In 1945, Saphir[12] described laryngeal edema and myocarditis in five children who died unexpectedly. He proposed that a more thorough microscopic examination of the heart would possibly solve some of these deaths. Tedeschi and Stevenson,[13] in their studies in 1951, showed that myocarditis was found more often in children than was commonly believed and represented a frequent manifestation of a generalized disease process. In most studies, however, myocarditis was given as an infrequent cause of death.

In a study of 52 cases of unexplained death, Spain et al.[14] found that 3 patients had

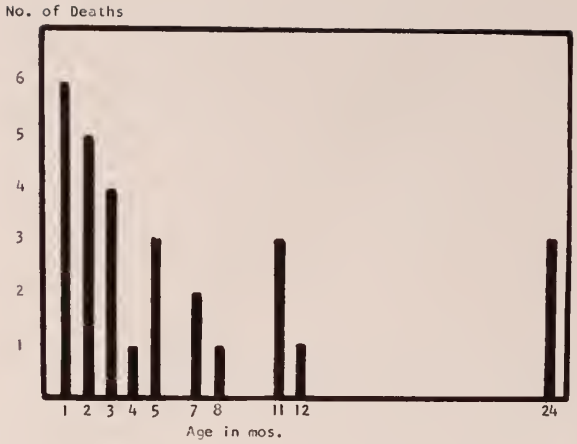

Fig. 1—Occurrence of sudden death according to age.

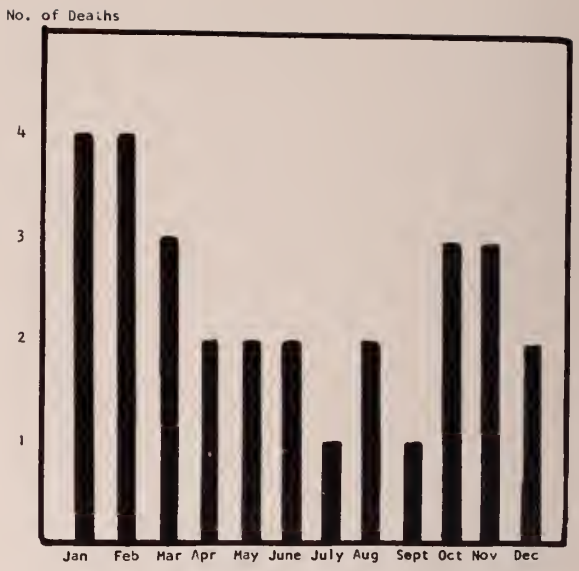

Fig. 2—Occurrence of sudden death according to month of year.

low gamma-globulin levels. They concluded that since peak levels for gamma-globulin occur at birth and the lowest level is between the second and third month, sudden death in many instances could be attributed to this. However, others[15] found no hypogammaglobulinemia.

In 1958, Valdes–Dapena[16] described 13 cases of focal fibrinoid necrosis of the larynx in 41 infants studied. Occasionally this lesion was associated with a myocarditis, and she suggested that this may represent a specific histologic lesion which by some mechanism results in death, possibly on the basis of an anaphylactoid reaction. Other investigators have noted this lesion infrequently but have attached no special significance to it.

Stowens[17,18] noted massive vomiting and/or bowel movement at the time of death. He interpreted this as being an over-all pattern of massive reaction by the autonomic nervous system. Some ill-defined irritation caused a generalized reaction resulting in bronchospasm and death. He labeled it as the "visceroviscerial reflex." This theory at present can not be proved or disproved.

Some investigators[2] discovered acute tracheobronchitis in their patients. One can propose that the associated edema in the tracheobronchial tree can produce a fatal tracheal obstruction and hypoxia. In many of the series[15,17,19] reviewed, tracheobronchitis was not frequently found as the mode of death.

Recently Parish et al.[20] proposed hypersensitivity to milk. They showed that children who were fed cow's milk developed antibodies. Repeated small aspirations of milk produce an antigen-antibody reaction of sufficient magnitude to cause shock and sudden death. They performed experiments on guinea pigs which tended to confirm their theory. This is another reason for urging mothers to breast-feed their babies.

Thus, we may conclude that except in the unusual case where gross or microscopic evidence of disease that would explain the death has been found, the problem of sudden and unexpected death in infancy remains unsolved. In the patients we studied we found a group of lesions which leads us to suspect that the mechanism of death in these patients depends upon a number of factors rather than on a single cause.

Report of Study

The material which we studied came from the infants declared dead on arrival at the hospital from the years 1955 through 1960. Most were investigated by the county coroner's office. At that time the circumstances of the death were checked. Foul play and accidental smothering were excluded in all instances.

There was a total of 29 infants in the group. More than one-half were 3 months of age or less at the time of death; 89 per cent were less than 12 months of age (Fig. 1). This is in accord with other studies.[7,15,19] All of the children were white; however, the number of negroes in comparison to whites is proportionately small in this county. There were 16 males and 13 females in the series which is similar to other reports.[7,15,19]

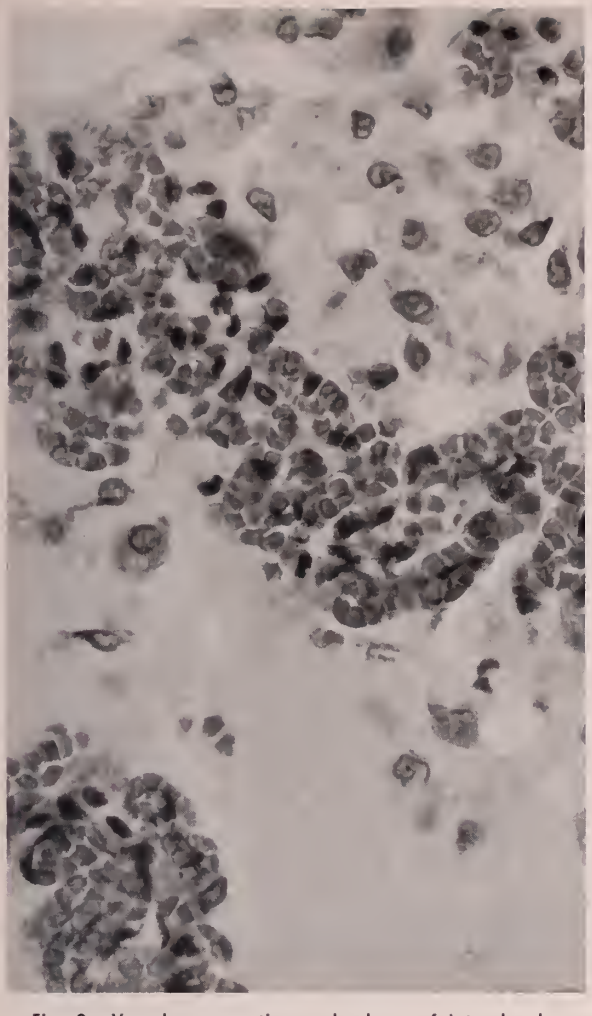

Fig. 3—Vascular congestion and edema of interalveolar septae along with intraalveolar edema (x500).

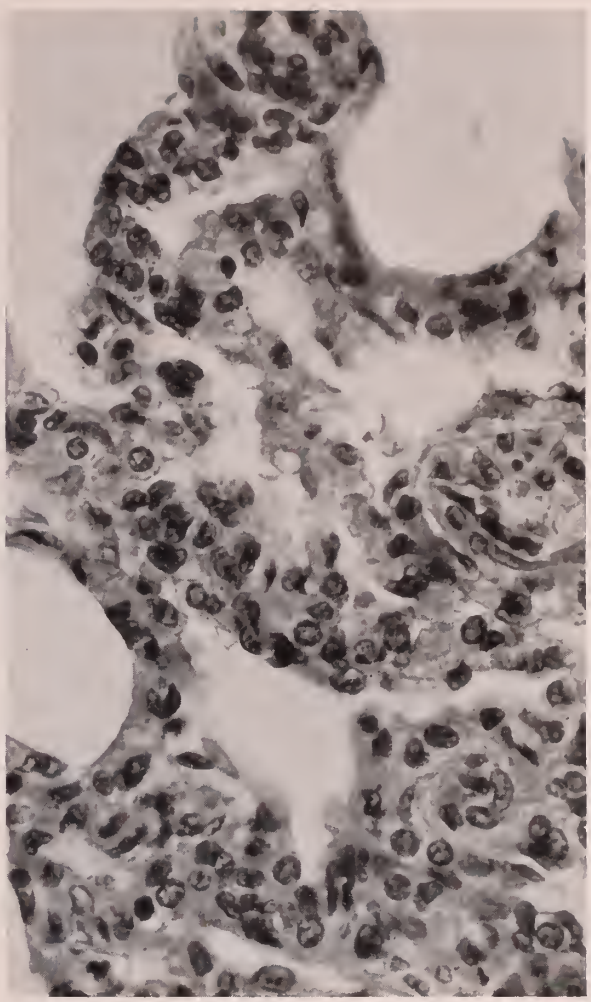

Fig. 4—Marked interalveolar thickening of the lung (x500).

Distribution of the 29 cases as to month of the year indicated that about 65 per cent of the deaths occurred between October and March (Fig. 2), the time during which respiratory diseases are most prevalent. Most investigators[14,15,21] found a peak in their studies during the winter months.

The family physicians stated that in most cases the child had been put to bed and when checked later was found dead. A history of an upper respiratory tract infection was obtained in a few instances, but at the time this was considered so slight that medical attention was not sought.

All of the autopsy protocols and slides were reviewed and the results tabulated. Complete autopsies were performed, including the central nervous system. The time between death and autopsy varied from 1 to 24 hours. Cultures for bacteria were routinely taken of blood, lungs, trachea, spleen and meninges. In certain cases tissue and body fluid samples were collected and sent to the State Laboratory of Hygiene for viral studies, and in three cases serum proteins were studied electrophoretically. Routine hematoxylin and eosin stains were done along with special stains when indicated.

The nose, mouth and upper airway were frequently filled with a frothy fluid or vomitus and occasionally no foreign material was identified. Scattered petechial hemorrhages were found on the pleural and epicardial surfaces as well as the thymus. The lungs contained an increased amount of frothy fluid and all the other viscera showed

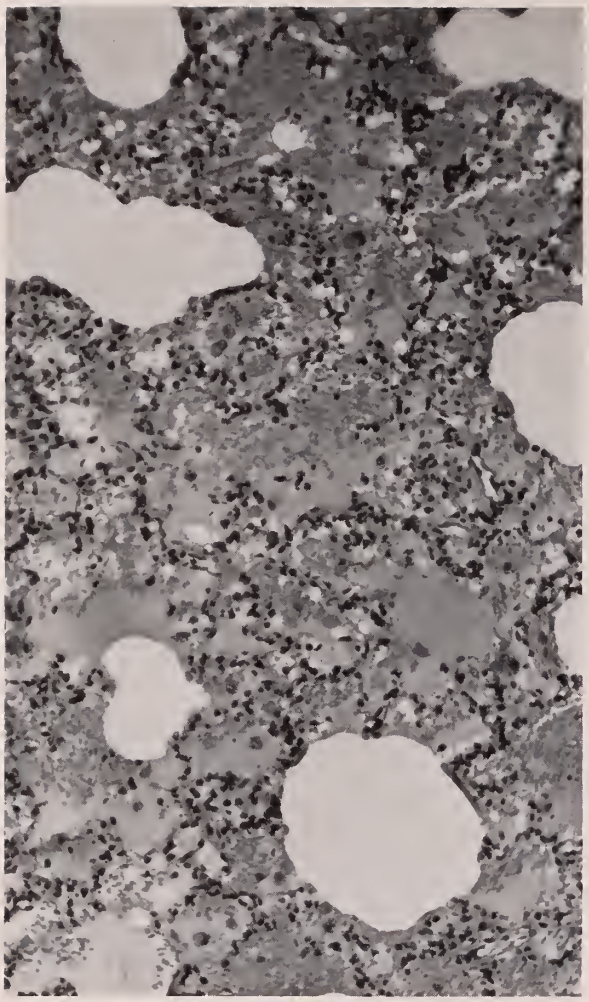

Fig. 5—Hemorrhagic congestion and intraalveolar edema of pulmonary parenchyma (x250).

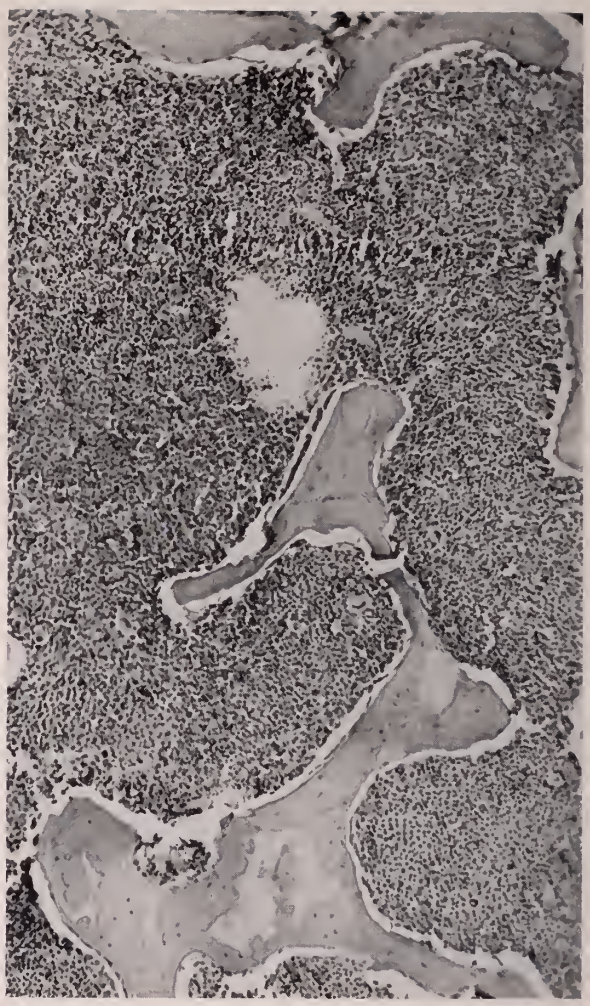

Fig. 6—Bone marrow showing normal spicules of bone with marked myeloid hyperplasia. No visible fat cells are present (x150).

moderate congestion. In most patients the lymph nodes were enlarged and hyperemic.

The constant pulmonary findings included patchy peripheral emphysema involving all lobes bilaterally with little, if any, central involvement. There were associated areas of focal atelectasis. The interalveolar capillaries were markedly congested and in most instances this was found along with edema of the interlobular septi and variable degrees of mononuclear cellular infiltration (Fig. 3, 4 and 5). Marked diffuse interalveolar edema occurred with the presence of nonlipid macrophages. Frequently peribronchial lymphoid hyperplasia was observed in the older age infants. The spleen and lymph nodes contained varying degrees of reactive hyperplasia of both the germinal centers and reticuloendothelial cells. The bone marrows were always of a hyperplastic nature (Fig. 6) which usually revealed an absolute eosinophilia and plasmocytosis, and a thorough search for viral inclusions in the body tissue was unrewarding.

These gross and microscopic findings were almost always found. On the basis of pathologic findings the series could be broken into two groups.

GROUP I: This group consisted of 11 of 29 patients (37 per cent of the total series) in whom a gross or microscopic condition was prominent and considered to be a cause of death. The principal finding in each of this group is listed in Table 1. The majority in this group had acute lesions of the respira-

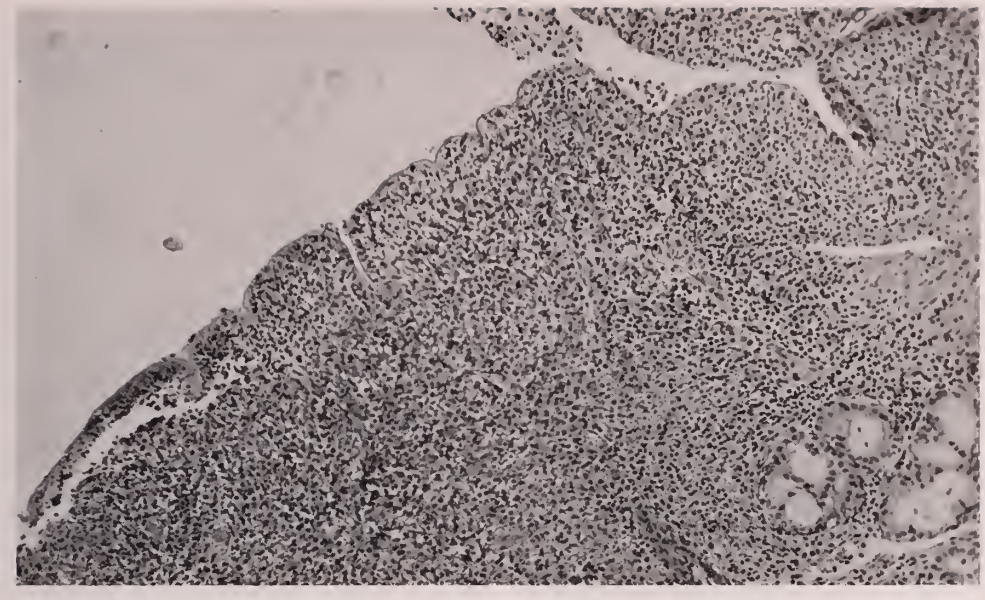

Fig. 7—Acute and diffuse inflammatory reaction of trachea extending from overlying epithelial layer down to the deeper underlying structures (x150).

tory system. The interstitial pneumonia group varied from the presence of polymorphonuclear leukocytes in the alveolar walls and intra-alveolar edema to one of fibrin and polymorphonuclear leukocytes in the alveolar spaces.

TABLE 1—*Listing of Principal Findings of Those Cases in Group I*

Pathologic Condition Considered Cause of Death	Cases
Interstitial pneumonia	5
Laryngotracheobronchitis	4
Staphylococcus aureus septicemia	1
Meningitis—Hemophilus influenzae	1

The cases of laryngotracheobronchitis included those with submucosal edema and an infiltration of segmented neutrophils into the mucosa and submucosa in varying amounts (Fig. 7 and 8). Some of the patients had a layer of fibrin on the mucosal surface. Only acute lesions were included because it was felt that the presence of scattered lymphocytes only in sections of the respiratory tract are common and do not denote a specific disease and are associated with normal reactive changes.

GROUP II: The remainder of our series was placed in this category. It consisted of 18 cases where no pathologic condition was present in sufficient degree to be considered the cause of death. In this group were varying amounts of pulmonary edema and congestion along with some interstitial thickening, but no segmented neutrophils could be identified. Many of the alveolar spaces contained macrophages which had a lacy or foamy cytoplasm. The remainder of the findings were as previously noted in the general microscopic description. Only on occasion (Fig. 9) was bronchial epithelial desquamation present which was in direct contrast to the finding of Parish et al.[20]

Staphylococcus aureus was cultured three times in Group I and Hemophilus influenzae was found twice in this group. Group II produced no positive bacterial cultures. Viral studies were done on body fluids and tissue in five of the cases for poliomyelitis, Coxsackie and ECHO viruses and none was ever isolated.

In three cases serum protein electrophoretic studies were done. These were found to be within normal limits and revealed no evidence of hypogamma-globulinemia or other protein abnormality.

Comment

Many efforts have been made to find a common etiology for sudden death in infants. In fact, many of the common findings in these deaths have at one time or another been listed as an individual cause. We found in our series and most other studies a histologic complex consisting of emphysema, pulmonary congestion and edema, interalveolar

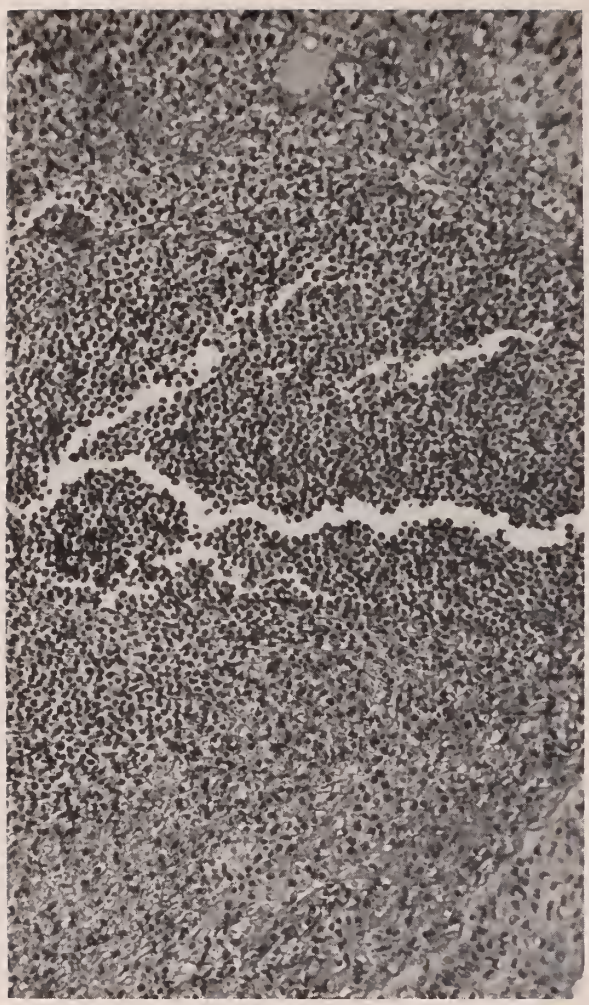

Fig. 8—Only a margin of overlying squamous epithelium of the trachea is present in this section. Beneath the epithelium in the center is found a microabscess composed of polymorphonuclear leukocytes (x150).

Fig. 9—Desquamation of the bronchiolar epithelium into lumen (x500).

thickening with an increased mononuclear infiltration, hyperplasia of bone marrow and reactive hyperplasia of lymphoid system. This histologic picture is suggestive of an infectious basis for the pathogenesis, but the paucity of viral agents isolated as well as positive bacterial cultures does not support this view. The most recent and encouraging study was by Gold[19] and his group who isolated 12 enteroviruses out of a group of 48 sudden deaths. However, there may be no single etiologic agent, and it may be a selective factor based on the maturity of the child.

We would like to make a plea to clinicians not to ascribe the death to suffocation. Admittedly the very weak child can suffocate, but the majority does not. To give the cause of death as accidental suffocation is unfair to the parents and may unnecessarily cause a guilt complex.

It is hoped that in the future centers, both large and small, will attempt to employ thorough techniques in evaluating these deaths. These should include a careful investigation by the police, social worker and family physician of all the circumstances prior to death. The autopsy should include examinations of all viscera, including the central nervous system, thorough bacterial and viral cultures, and serum protein electrophoretic studies. By the adoption of similar methods of study a combined, though geographically separated, effort can be instituted.

Summary

Sudden unexpected death in infancy is one of the enigmas of our age. The various theories for its cause have been outlined and

a short comment on each has been made. A review of 29 cases in one county studied at the hospital has been presented. It has been shown that a histologic complex is apparent in these deaths which is suggestive of an infectious agent, although it has been quite difficult to isolate a specific organism.

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ACKNOWLEDGMENT: We are indebted to the Madison General Hospital Surgical–Medical Foundation for its assistance in the preparation of this manuscript.

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The State Laboratory of Hygiene and Dr. William D. Stovall

One of the greatest challenges and accomplishments in the multi-faceted career of Dr. William D. Stovall is the present State Laboratory of Hygiene. After six months at the University of Wisconsin, Doctor Stovall was placed in charge of the laboratory—that was in 1914. He remained its director until 1958 when he retired from that position.

During his tenure, the laboratory volume of work grew from some 9,000 specimens in 1914 to approximately 500,000 in 1957. The staff grew from 6 to 90 people.

Another appraisal of the span of service of Doctor Stovall lies in the facts that the laboratory has had three locations, the latest of which is the new building which was built in 1950 at a cost of $1,600,000. It is described by Doctor Stovall as "beautiful, functional, and adequately staffed for the application of the various physical sciences to the control and prevention of disease." Others call it "a living monument to Doctor Stovall's efforts in this state."

Able, efficient organization and a knack of tireless leadership have characterized his service at the State Laboratory of Hygiene.

His challenge—"the extension of laboratory services to every doctor in all parts of the state, thereby helping to create a more sanitary and healthful environment in which to live . . . offering laboratory services to doctors in isolated areas which they couldn't get otherwise"—has been met and remains as one of his outstanding contributions to public health.

State Laboratory of Hygiene on the University of Wisconsin Campus

STATE MEDICAL SOCIETY OF WISCONSIN

The W. D. Stovall Commemorative Entrance

Recognizing the great admiration of Doctor Stovall for the home of the State Medical Society of Wisconsin, the Dane County Medical Society constructed a commemorative entrance to the grounds of the Society in Madison so that his manifold contributions would be permanently remembered.

The memorial niche at the entrance site contains a plaque which reads:

> Erected in honor of William Davison Stovall, M.D., distinguished physician, scientist, teacher, medical statesman who has dedicated his life to human welfare.
>
> Presented by Dane County Medical Society
>
> 1958

W. D. STOVALL, M.D.
at the memorial niche
which contains the plaque

AT DEDICATION OF the Society building in 1955, Doctor Stovall said: "A dedicatory ceremony is not only a commitment for the future; it is a commemoration of the past. It has been said that history is the essence of innumerable biographies. It is in this sense that today we recognize that those men and women who have preceded us made preparation by thought and action for the occasion which we are now celebrating. Their conduct and planning made it possible to dedicate this building to continued improvement in the care of the sick and in the health of the people of Wisconsin."

PRESIDENT'S PAGE

His Light Shines

"LET YOUR LIGHT so shine before men, that they may see your good works and give glory to your Father Who is in heaven." MATTHEW, 5:16.

In addition to those of my family who had the responsibility of raising me and trying to get my feet pointed in the right direction there are two who always come to mind, my third grade teacher and Dr. William Davison Stovall.

The former has long passed to her reward but her light still shines for me in my third grade copy book. The latter is still very much in our midst, and there is no dimming of this light which over the years lighted the path for many an embryo physician.

It was my good fortune to live in the Stovall home for one school year as a medical student. For this I am grateful and wish to thank him for one of his many good works.

His light shines!

Leigh H. Lockhart

STATE MEDICAL SOCIETY OF WISCONSIN
MEDICINA NUSQUAM NON EST

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Giant Among Us

IT WOULD TAKE the oratorical flair of the subject himself to properly picture his place on the Wisconsin medical panorama. Who among thousands of alumni will ever forget the dramatic monologues that comprised Doctor Stovall's course in clinical diagnosis? The glamour of medicine that long before enticed the teen-aged scientist into the most noble and exacting of all professions was suddenly revealed to him with dazzling purity, shorn of the trivia clouding the immature image. The astonishing excitement that Doctor Stovall could impart to such pedestrian procedures as urinalysis and blood films somehow resolved all hesitancy about the future—the student would henceforth devote himself to the simple objective of becoming a *good* doctor.

Words such as wit, probity, buoyancy, urbanity, resolution, industry, virtue, sterling, gracious, courage, audacity, humanity, excellence, affability, and many more, tumble about when speaking of Doctor Stovall, and there is no stopping them. There is, in fact, some risk that as he reads the columns of tribute in this issue he will be moved to pinch himself and ask, "Am I still among the living?"

But nothing could be more appropriate, more timely, than the dedication of this issue of the *Wisconsin Medical Journal* to Dr. William Stovall—scientist, educator, administrator, leader—the complete physician, quite predictably unwilling to rest on his laurels, and participating even now in the good fight with undiminished vigor. *Invia virtuti nulla est via* best describes the multi-faceted career of this superlative gentleman to whom we pay honor.

It is a tiny token of esteem for the honor he has brought to the State of Wisconsin and the profession of medicine. —D. N. G.

GUEST EDITORIAL

Recruitment for Medicine

ALTHOUGH the number of medical school applicants has remained relatively unchanged since 1953, there are several reasons for concern about the need for a completely adequate supply in quality and quantity of medical students.

First, the increase in the number of openings in new schools and expansion of existing schools has diluted the pool of applicants.

Second, students with superior academic records, who formerly entered medicine, are pointing their careers towards other fields. The percentage of medical school applicants with an "A" average has decreased from 40% to 15%.

Third, the financial demands of medical school, the internship and extended residency training do not compare favorably with the full fellowship support and attractive beginning salaries in other fields.

These facts add up to a highly competitive situation where medicine must take a more positive approach toward recruitment. Discussions with high school students, visits to colleges, conferences with pre-medical advisors and science shows can play a part. With the Commission on Medical Education of the State Medical Society, Marquette and the University of Wisconsin are vigorously attacking these problems. Despite apprehensions about the future patterns of medical care, the medical profession should encourage our youth to enter medicine. An adequate supply of good doctors is the best assurance that medicine will not lose its identity.

There is a clear and urgent need for additional scholarship and loan funds for medical students. The Charitable, Educational and Scientific Foundation of the State Medical Society is making a very real contribution to this problem through the availability of loan funds. Yet larger resources are needed and must be forthcoming if medicine is to meet the challenge. We should be able to assure any well-qualified applicant that loan funds will be available if a need exists.

At the level of the Resident House Officer, there is a rising ground swell to support more realistic stipends. Beginning stipends of $5,000.00 might be more in line with services delivered and professional responsibility than existing stipends of about $3,000.00. It has been suggested that these funds should be obtained in part by collecting insurance fees when residents perform surgical procedures.

On the average each American saw a doctor once a year in 1920 and five times in 1960. As the demand for medical services increases, the demand for more physicians will increase in a comparable manner. Recruitment for medicine through joint efforts between the medical profession and the medical schools is an urgent problem.—JOHN Z. BOWERS, M.D., *Dean; and* ROBERT D. COYE, M.D., *Assistant Dean, University of Wisconsin Medical School*

FROM THE PRESS

A. M. A. Political Program Has Far to Go in Wisconsin

The American Medical Association, says an announcement prominently played in the nation's press, is about to launch a political action auxiliary.

Whatever that development may mean in the tactical designs of the AMA which has had such a controversial role in the politics of the country lately, the politicians of Wisconsin are not likely to hold their breaths waiting for the execution of the design in local terms.

For the practicing medical men of Wisconsin have been as reluctant and indifferent about normal political activity as any organization with a direct stake in political and governmental policy that can be named. Some of their present political worries, indeed, may be ascribed to the fact that the practicing politician has in so many instances lost confidence in the political awareness and the political punch of the doctors as an interest group.

HOW IT GOES: The medical lobby in the Wisconsin legislature is perhaps a clinical example of the declining stature of the medical man in his civic capacity—as a force upon the politics and legislation of his time. The professionals representing the medical arts are competent and diligent men.

They watch proceedings attentively, they make lawyer-like arguments, and they exhibit a considerable concern for the public interest as well as the professional concerns of their clientele when they involve themselves in general public welfare and public health subjects as well as those affecting the regulated and licensed profession.

But they have virtually no backing, in practical terms, from the practitioners whom they are representing. The doctor who will turn up in a legislative committee room for direct participation in the political struggle is a rarity.

That absence from the struggle is also characteristic of the profession in the more mundane aspects of political life—as in political campaigns and political party organizations. There was a time when the small town doctor was almost automatically, by virtue of his rank as a professional man and the respect in which he was held by his patients and neighbors, a political leader in the community. The number of medical men in either party who are now active partisans can be counted on two hands. Democrats generally tend to regard physicians in any typical county as Republican in sympathy. But that assumption has come to be something of a wry joke to the Republican party workers and leaders, who know better.

SELECTIVITY: A couple of months ago the Dane County Republicans held a county organization meeting. Dane County is one of the chief medical centers of the state. It has an extraordinarily high population of physicians and surgeons and related practitioners. A chiropractor was running for the county GOP chairmanship. Some of the Republican doctors thought he should be defeated. But he won, by a single vote, in a small caucus.

The superior political action skills of the chiropractors in spite of their numerical inferiority probably also account for the fact that the Wisconsin assembly in several recent sessions has approved a chiropractor-sponsored bill that the medical society solemnly warns is against the public interest. This reporter doesn't pretend to judge here the merits of that proposition. But it must be crystal clear by this time that this measure, which hasn't reached the statute books and perhaps won't, is passed each year by one house of the legislature as a kind of oblique testimony of these practical politicians about the political indifference of the doctors, and their resentment of it.

It may also be a hint that the politicians on the firing line are disappointed that the doctors are so selective in their political interests. When the issue of government medicine arises, the doctors excitedly denounce it and comb their neighborhoods for allies. The rest of the year they are above and beyond the fight that involves all citizens, by definition. The AMA political action experiment may be another example of this selectivity. The politicians will be watching skeptically.
—JOHN WYNGAARD, *Madison representative for GREEN BAY PRESS-GAZETTE and APPLETON POST-CRESCENT, July 31, 1961, column, reprinted with permission.*

FIVE NEW MEDICAL FILMS AVAILABLE

Winthrop Laboratories has added five new medical motion pictures to its film library and has announced that they are available immediately for professional showings.

Prints of the movies are available free for showing to medical and scientific organizations, medical students and nurses, hospitals and other professional teaching institutions. Requests for prints should be addressed to: Winthrop Laboratories, Motion Picture Department, 1450 Broadway, New York 18, N. Y.

The five new movies are 16mm. color and sound productions. Their titles are: "Avoiding Complications of Spinal Anesthesia", "Epidural Anesthesia for Vaginal Delivery in Obstetrics", "Hepatic Trauma, New Concept of Surgical Repair", "Transvaginal Regional Anesthesia in Obstetrics" and "Disinfection of the Skin".

"Avoiding Complications of Spinal Anesthesia," 30-minute running time, reviews potential complications resulting from subarachnoid injection of regional anesthetics, and the means of preventing them.

"Epidural Anesthesia for Vaginal Delivery in Obstetrics," 22 minutes in length, deals with the advantages of epidural anesthesia for the mother and the unborn child.

"Hepatic Trauma, New Concept of Surgical Repair," a 20-minute movie, shows a new and highly successful method of lowering morbidity and mortality rates in patients with hepatic trauma.

"Transvaginal Regional Anesthesia in Obstetrics," 27-minute running time, demonstrates the effectiveness of regional block anesthesia. Climax of the film is the delivery of identical twins.

"Disinfection of the Skin," a 24-minute movie, shows technics for cleansing the skin of operating room personnel, proper use of various disinfectants, and preparation of the patient's skin.

Editors
HARRY BECKMAN, M. D., Marquette University
F. E. SHIDEMAN, M. D., University of Wisconsin

Monoamine Oxidase Inhibitors

By JAMES L. WAY, Ph.D.
Madison, Wisconsin

A CLASS of drugs, principally hydrazine derivatives, recently has been developed which inhibits the enzyme, monoamine oxidase. A few monoamine oxidase inhibitors which may be of clinical importance are: isocarboxazide (Marplan), phenelzine (Nardil), nialamide (Niamid) and tranylcypromine (Parnate). Isocarboxazide, phenelzine and nialamide are hydrazine derivatives, and tranylcypromine is a nonhydrazine derivative.

Since these agents are potent inhibitors of monoamine oxidase activity, one proposed mechanism of action is the inhibition of the metabolic disposition of amines, causing elevated levels of serotonin, catechol amines, and other naturally occurring amines. However, with the therapeutic doses employed in man, there is some question whether these drugs do exert their effects as enzyme inhibitors of monoamine oxidase.

One of the initial pharmacological effects observed with these inhibitors is an alteration of psychomotor activity. Usually a stimulation occurs; however, in some individuals a depressant effect or no effect may be observed. These inhibitors also exert a blocking action on the autonomic nervous system. Some of the autonomic inhibitory effects are: postural hypotension, dryness in the mouth, vascular headaches, urinary hesitancy, constipation and increased warmth of the extremities. The clinical responses of many unrelated drugs have been potentiated by these inhibitors and conversely these inhibitors have been potentiated by various drugs, usually oral diuretics.

In regard to their therapeutic usefulness they are not specific for any disease; however, symptomatic improvements may result from their use. Since monoamine oxidase inhibitors cause an increase psychomotor activity, they have been employed as psychotherapeutic agents in the treatment of depressive states. They also have been employed as supplementary therapeutic agents in the treatment of individuals with connective tissue diseases. Reports on the efficacy of monoamine oxidase inhibitors in the treatment of angina pectoris have been contradictory. Controlled clinical studies suggest that these inhibitors do not have a significant effect on relieving anginal pain.

After oral administration of a monoamine oxidase inhibitor, there is usually a latent period from days to weeks before the effects of the drug become apparent. These effects may persist from a few days to a few weeks after therapy has been discontinued. The daily doses of some of the inhibitors are as follows:

1. Phenelzine (Nardil)—30 to 45 mg. is administered in divided dosage at 8-hour intervals. After a few weeks the daily maintenance dose is reduced to 5 to 20 mg.
2. Isocarboxazide (Marplan)—20 to 30 mg. is administered as a single daily dose. The maintenance dose is reduced to 10 mg. or less.
3. Nialamide (Niamid)—100 to 300 mg. is administered as a single daily dose. After improvement occurs, the maintenance dose is reduced to 50 to 100 mg.

Although the incidence of toxicity from these monoamine oxidase inhibitors is low when the dosage is well regulated, the toxic effects which do occur can be serious. A number of severe toxic reactions and fatalities have been reported from the hepatotoxic effect of these drugs. The manufacture of pheniprazine (Catron) and iproniazid (Marsilid) recently has been discontinued as a result of their toxic properties.

How Much Do We Know About the Aged?

By WILLIAM F. STEWART

Madison, Wisconsin

THE CONCERN with the "problems" of our aged population has been accelerating at an ever-increasing rate until there is a demand for action "Now!" Meanwhile, our systems of gathering and analyzing information have not been able to keep pace with the demands being placed upon them. One major example of the inadequate data in this field is our present knowledge regarding the incidence and prevalence of morbid conditions among the aged, the proportion of these conditions that are untreated, the rate of hospitalization, and the resources available to pay for these needs. On a national level there are several very good sources of information, at a state level there is practically nothing. Nevertheless, contracts must be drawn, benefits determined, and a budget provided for various proposed systems of health insurance operating at the state level.

Among the innumerable factors that can influence the needs and demands for health care and insurance are certain pervasive socio-economic variables that are changing rapidly at present. We are just beginning to feel the full effects of programs initiated nearly thirty years ago and many of these consequences are not forseeable or predictable. Furthermore, the programs themselves are constantly undergoing change as in the case of the recent lowering of the voluntary retirement age for males to 62 under the Social Security system. The full impact of such a change on nursing services, hospital loads, nursing homes, and so forth can hardly be predicted.

In order to understand some of these factors better, the State Board of Health has recently completed a comparison of the living arrangements and money income of the United States' older population in 1950 and 1960.[1] Some highlights of the findings are presented here. All observations refer to our population aged 65 and over.

1. Nearly 70% of the males in 1960 were married and living with their wives, but only 35% of the females were similarly living with their spouses.
2. Nearly 30% of the aged females were living in their own households without relatives.
3. The number of females over 65 years of age increased an impressive 41.5% in the last ten years, but the males gained only 29.5%.
4. The number of aged women living alone in their own households increased 101.4% since 1950. Males in this category jumped 56.0%.
5. More than three-fifths of those not eligible for O.A.S.I. benefits were aged 72 and over.
6. For both sexes, the proportion living alone without relatives increased with age despite their lower incomes and greater infirmities.
7. Forty-three per cent of all males who were living alone were over 75, while 38% of the females in this situation were over 75.
8. Four out of five women aged 75 and over were unmarried.
9. Considering those individuals with less than $1,500 total money income, and those married couples whose combined income is less than $2,000 as "medically indigent," then, the size of this group in Wisconsin is estimated to be 173,400 persons.
10. Those who are 75 years and over probably account for nearly 47% of this medically indigent population.
11. Females comprise nearly 63% of the medically indigent and at least 56% of the total group were unmarried.

Certainly, the above mentioned characteristics and their probable future trend have important implications for the health needs, the demand for services, the utilization of hospitals and nursing homes, the ability to pay, and the insurance programs required. Our greatest need, however, is for statewide sample surveys on a continuous basis to supply the needed data. Unless we can trace these rapidly changing conditions any planning will necessarily involve much guesswork.

Mr. Stewart is Director, Statistical Services, Wisconsin State Board of Health, Madison.

REFERENCE

1. Bureau of Vital Statistics, Wisconsin State Board of Health, *The Living Arrangements and Money Income of Wisconsin's Older Population,* Special Report, April 1, 1961.

THE MEDICAL FORUM

Physicians And Federal Agencies Join Forces To Start All-Out Campaign Against Quackery

Wisconsin Physicians At National Meeting

The nation's physicians and federal agencies banded together to start an all-out campaign to rid the country of medical and health quackery at the first National Congress on Medical Quackery held October 6–7 in Washington, D. C.

Dr. Robert Zach, Monroe, and Dr. Robert Samp, Madison, attended the conference as representatives of the State Medical Society of Wisconsin. It was sponsored by the American Medical Association and the Food and Drug Administration.

Taking part, in addition to the sponsors, were the Justice Department, Federal Trade Commission, Post Office Department, American Cancer Society, Arthritis and Rheumatism Foundation, National Better Business Bureau, Federation of State Medical Boards of the United States, and Science Writers and Editors.

SHAKE OFF THE POUNDS is the motto of this device, viewed at the National Congress on Medical Quackery by Dr. Robert Zach, Monroe, and Dr. Robert Samp, Madison. The two physicians were Wisconsin's representatives at the conference.

RIBICOFF SPEAKS

Secretary Abraham A. Ribicoff of the Health, Education and Welfare Department, told the more than 600 delegates that quackery costs its victims more than $1 billion a year.

"But quackery's cost in dollars only introduces the story," he added. "In terms of false hopes raised, in terms of delusions fostered, in terms of tinkering with human life itself, the cost cannot be measured."

Said AMA President Dr. Leonard W. Larson, "We must wage psychological as well as scientific warfare" against quacks. "We must not only prove the worthlessness of quackery but we also must establish confidence in sound medical and health care."

VITAMINS AND SUPPLEMENTS

Under direct fire of FDA Commissioner George P. Larrick were vitamin products, special dietary foods and food supplements, which he called "the most widespread and expensive type of quackery in the United States."

Larrick also appealed to state and local enforcement agencies to act against quacks using mechanical treatment devices banned by court order. He listed a "top twenty" of these devices which have been the subject of court action, but the FDA has cause to believe that there are a large number of these devices still in use throughout the country.

One of the twenty is the "Neurolinometer," the little black box sold by I. N. Toftness, Cumberland, Wisconsin, chiropractor, before the federal court pronounced

(Continued on page 586)

URANIUM ORE as a quack treatment is discussed here by Wallace F. Janssen, of the Food and Drug Administration, and Dr. Robert Samp, Madison, during the National Congress on Medical Quackery in Washington, D.C. Such uranium ventures mushroomed in Wisconsin in 1954 and 1955 until the State Medical Society, Attorney General's Office, and other agencies acted to close them.

Start All-Out Campaign Against Medical And Health Quackery

(Continued from page 585)

it worthless in 1958 and banned its sale.

Evidence that the FDA's suspicion that some of the "top twenty" devices might still be in use around the country came out in testimony at a Wisconsin legislative hearing this year. A chiropractor indicated that the neurolinometer's successor—called a "research model"—is in use by chiros in the state.

Further evidence that this is so came when the Legislature refused to reappoint a member of the Board of Examiners in Chiropractic because of complaints that he failed to take any action to ban the use of the "research model" by Wisconsin chiropractors.

NEED FOR ENFORCEMENT

Speaking for State Board of Medical Examiners, Dr. Harold E. Jervey, Jr., pointed out that there is room for improvement in state legislation, and in enforcement of laws already on the books. Additional federal legislation, he felt, is not needed.

Doctor Jervey singled out only four state boards with wide experience in control of quackery. "This is astounding when it is realized that almost all of the states possess a statute empowering the board to proceed against anyone practicing medicine without a license," he added.

Some of the reasons he listed for insufficient action by state boards:

1. A shortage of money, and consequently inadequate personnel for investigation and preparation of evidence.
2. When funds are available, boards have found it difficult to obtain sufficient evidence for prosecution, primarily due to reluctance of witnesses to testify.
3. From a recent survey it would appear that the FDA and state boards have little contact with each other.
4. Few states have severe enough punishments to be meaningful. Once quacks have paid a fine, or served a few days in jail, they start in at another locality.
5. Some boards have experienced difficulty in getting attorney generals to prosecute whether on the county or state level.
6. There is a need for an interchange of information between all of the state boards on the types of quackery seen, who these men are, and the cases brought to court.
7. Some states lack injunctive processes to stop quacks from operating.

"Laws, if not properly enforced, are of no value and that is one of the primary needs today," he stated.

"We should insure that our legislators understand the problems and adequately finance those agencies empowered to do the job," Doctor Jervey said.

"In this regard it might be pointed out that if only a small portion of the money spent on investigating the drug industry and other like groups had been available in this area the health and pocketbooks of the American people would have been far better protected."

"It is a paradox of our times that citizens of high and low rank alike fritter away their time fruitlessly investigating for flaws in the legitimate and honorable bastions of our civilization while the obvious morasses of culpability and degeneracy go relatively unheeded and unheralded," he concluded.

CANCER CURES

Oliver **Field**, director of the AMA's Department of Investigation, explained the American Medical Association's long history of fighting quackery, with files of information going back more than 50 years.

"Nowadays cancer cures constitute the largest single category having the interest of the families and friends, physicians . . ., government agencies, and others," he said. "Of great interest, from the standpoint of inquiries received from the public, are vitamin pills."

He also had some significant words on chiropractic, which are reprinted in another article in this issue of the *Forum*.

As an example of effective combatting of quackery, Field cited a case where the FDA, county medical society, and board of medical examiners all descended on a quack just starting in business a few years ago. "It takes a program which seeks to acquaint the public with the problem, and

(Continued on page 587)

A MAGNETIC RAY, emanating from the belt viewed by Dr. Robert Zach, Monroe, is one of the quack cures in an exhibit at the First National Congress on Medical Quackery held in October. With Doctor Zach is Wallace F. Janssen of the Food and Drug Administration, which is active in the fight against quackery.

Start Drive On Quackery

(Continued from page 586)

swings into action quickly when there is a threat to the community or to the nation at large," he said.

SOME DIFFICULTIES

Speaking for the department of Health, Education and Welfare, William W. **Goodrich**, assistant general counsel for food and drugs, told the meeting: "All the talk in the world . . . will have no effect unless backed by a strong and determined enforcement program . . . unless we are willing to act in areas of entrenched interest, which surely will involve us in costly and difficult litigation."

Outlining some of the difficulties in putting the quacks out of business by legal action, Goodrich said: "In medicine, the claim is presumed to be false until it has been established as true by reliable pharmacological and clinical experiences."

"In law, a medical claim is presumed to be true until the government is prepared to prove its falsity by a preponderance of the evidence or beyond a reasonable doubt. And the question in any case is not whether the drug sometimes fails; it is whether the drug *ever* works."

Goodrich made a particular plea to local and state authorities, state licensing boards, and county and state medical societies to "be bold in striking at those who practice quackery."

"Local attitudes are that nothing can be done; that the local prosecutor would not prosecute and a local jury would not convict. We don't believe it."

"We think what is required is motivation. If the local authorities are mindful of the grave dangers, they will be determined to stamp them out. It can be done. We have yet to lose one of these cases when the problem was laid bare before the court and jury," he concluded.

Milwaukee Nurse Is Named To Committee

The State Board of Health has announced the appointment of Miss Emma **Kuehlthau**, R.N., director of the Milwaukee Visiting Nurses Association, to a three-year term on the advisory committee on nursing homes.

NAME GUEST LECTURER FOR "DEARHOLT DAYS"

The Wisconsin Anti-Tuberculosis Association has announced that Dr. John P. **Wyatt**, professor of pathology at St. Louis University School of Medicine will lecture on the "Pathodynamics of Emphysema" at the 1961 Dearholt Days lectures.

Doctor Wyatt will speak at Marquette University School of Medicine on Tuesday, November 14, and at the University of Wisconsin Medical School on Wednesday, November 15.

The lectures commemorate Dr. Hoyt **Dearholt**, founder of the WATA, and are sponsored by the medical schools and the WATA.

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AMA Executive Calls For Drive To Stem Tide Of Chiropractic

The cult of chiropractic came in for particular attention at the first National Congress on Medical Quackery, held in Washington, D. C., October 6–7.

Oliver Field, director of the AMA's Department of Investigation, stated, "There are other problems, but none more serious than that of the person who seeks to practice medicine, or the follower of a system of medicine who victimizes trusting people by causing them to delay or abandon competent medical attention."

"It takes a pretty good man to know when to exert the art and when to apply the science (of medicine)," he said. "Not so with the quack. He is always there with the most acceptable bedside manner. He is the exploiter who is quick to join in his community the service clubs and a church, and to get himself socially accepted and to be recognized as 'Doctor.' These are parts of the courses which are offered to naturopaths. chiropractors and the like."

"The art is stressed to such an extent that science goes out the window. The net result, of course, is that the person who is suffering from organic disease is victimized by losing his money and at the same time having his health deteriorate as though he were getting no treatment at all."

"The medical profession needs help in stemming the tide of such things as chiropractic," he continued. "We are fairly certain that naturopathy is on the wane."

"But there runs through the thread of legality in the whole United States, except in four notable exceptions . . . this business of chiropractic."

"As one sage has observed, all the tribes of the earth love to have their backs rubbed, but it remained for the Americans to make a profession out of it."

"Suffice it to say that the chiropractor has been taught to act as a persecuted member of the healing fraternity," Field continued. "As such, he has been more brainwashed than given an education which would enable him to progress, to find new advances which would lead to achievements in the field not only of diagnosis and therapy, but possibly of preventive medicine."

"Only recently have the chiropractic organizations realized that it is to their advantage to recognize the possibility that germs might cause disease. Their reasoning that a body without a vertebral subluxation is one more vulnerable to disease can be answered without too great an effort by referring to a standing offer (who made it, I cannot say) that one might take any twelve chiropractors, inoculate six of them with the spirochete of syphilis, and invite the other six to adjust it out of them."

"These are great problems because they alter the course of scientific exploration and scientific effort in the area of competent medical care for the greatest number of people," Field said.

"The campaign, then, should be positive, in that it should seek to dissuade and discourage youngsters from following a fraudulent course by enrolling in chiropractic schools.

"Attention should be given to high schools, academies and junior colleges. No one can expect or hope to keep all people from being lured into such a fraudulent system of healing, but as long as the minimum is achieved, chiropractic will dry up for want of nourishment to its roots—namely, matriculants in its schools."

"Now, the government of the United States has sponsored and spawned quackery by giving its returning veterans the means whereby they could attend chiropractic schools," Field stated.

"Let us hope that the Congress will be sufficiently advised in the matter of squaring accounts with returning veterans that chiropractic is not one of the areas that is worthwhile, that give promise, or that is a legitimate method of treating disease."

Chiros Accuse M.D.s Of Copying Techniques

The best defense is a strong offense, especially if your defense won't stand close examination.

And offensive is a good word for a plea advanced at the 10th annual meeting of the Wisconsin Chiropractic Society calling for "remedial legislation in Wisconsin and other states which would prevent unqualified members of the medical profession from practicing chiropractic techniques."

O. L. Hidde, Watertown chiropractor, said an increasing number of chiropractic patients are reporting attempts by physicians to duplicate manipulative treatment of chiropractors.

"Chiropractic treatment at the hands of untrained M.D.'s can prove harmful to the patient," Hidde claimed. "Doctors of chiropractic receive four years of intensive college training and must intern before they are allowed to practice, yet many M.D.'s are attempting treatment similar to chiropractic by reading textbooks or attending a few lectures on the subject."

He went on to criticize the "political arm of medicine" for continuously harassing the chiropractic profession and said that most physicians would not furnish x-rays to chiropractors, thus causing the patient further expense of duplicate x-rays.

Medical Students Learn About Society Activities

Students in the University of Wisconsin Medical School class on Community and Industrial Health met Tuesday, September 12, at the State Medical Society building in Madison.

The medical students heard presentations on "Organization and Functions of Your Medical Societies," "Legal ABC's for the Young Physician," and a discussion of "General Practice vs. Group Practice."

In the latter discussion, talks were given by Dr. Phillips T. Bland, Westby, a general practitioner, and Dr. Leslie G. Kindschi, Monroe, specialist in internal medicine.

The students also toured the State Medical Society building.

OUTDOOR ADVERTISING CAMPAIGN, kicked off this month by WPS, features advertisements such as the one above in selected communities where independent insurance agents sell WPS non-group coverage. WPS district offices, which sell health care protection to groups, will also benefit. The strip at the bottom of the poster will contain the name of the local agency or district office.

WPS Agencies Kick-Off Major Outdoor Advertising Campaign

A comprehensive Wisconsin Physicians Service advertising campaign, to promote the sale of non-group health care protection, will kick-off the latter part of October and early November in various communities around the state.

Heart of the campaign will be a series of 36 outdoor signs centered around communities where independent insurance agencies sell WPS health insurance to individuals and families.

The agencies, in turn, will supplement the outdoor advertising by running advertisements in their local newspapers, mainly at their own expense.

Cities and towns near which the signs will be erected are: Amery, Eau Claire, La Crosse, Viroqua, Marshfield, Beaver Dam, Waukesha, Kenosha, Alma, Green Bay, Adams and Madison.

WPS district offices in Green Bay, Kenosha and Eau Claire, and the home office in Madison, all of which sell WPS group insurance, will also benefit from the campaign.

A series of three different posters, to run at selected time periods during the next 12 months, is under preparation. The first is pictured above.

NEW WPS PLAN FOR TEACHERS, COUNTY MUNICIPAL GROUPS

A specialized group health insurance offering to teachers groups, county employees and municipal employees was launched in September by Wisconsin Physicians Service.

The program, entitled "Select Risk," offers both surgical-medical and Hospital benefits, as well as major medical benefits if the group wishes this additional coverage.

Groups which qualify, through good experience ratios in the past and other criterion, enjoy reduced rates.

NEW LAW ON COUNTY HEALTH COMMISSIONS

Governor Gaylord Nelson has signed a bill (2, S.) into law, which enables counties to establish county health commissions to replace town health officers.

The original bill would have eliminated the 1,700 town health officers in the state, with each county having a health commission. The measure was amended, however, to make it optional, turning the problem over to the counties.

In addition, a 60-day time limit —starting with the first meeting of the county board following the Governor's signing of the bill— was written into the new law. If the county fails to act in that time, the law will become inoperative.

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32nd Division Soldiers Advised On Medicare By State Society

Members of Wisconsin's 32nd Division, called to active duty, have received a letter from State Medical Society President Dr. Leif H. Lokvam, Kenosha, explaining the operation of Medicare, the federal government's health care program for dependents of servicemen.

Enclosed with the letter was an outline of the benefits available under the Medicare program.

For the care of dependents in Wisconsin, the federal government has contracted with the State Medical Society to administer the surgical-medical benefits and with Mutual of Omaha to administer hospital benefits.

Said Doctor Lokvam:

"If while you are on active duty your dependents have any question about Medicare benefits in Wisconsin, we will be happy to assist in resolving the problem."

For information on surgical-medical benefits, questions may be sent to: Medicare, c/o State Medical Society of Wisconsin, Box 9, Madison 1, Wisconsin.

Questions concerning Medicare hospital benefits may be sent to: Mutual of Omaha, Omaha, Nebraska.

When applying for any kind of medical care, dependents are required to present their Medicare identification card as proof of eligibility.

If these identification cards did not arrive prior to the division's departure, Doctor Lokvam stated that when emergency care is required, dependents may use some other positive identification when requesting medical care. A signed statement from the serviceman plus the dependent's driver's license or Social Security number is sufficient.

In addition, the president of the Society advised the departing servicemen to look into options of their voluntary health insurance coverage concerning continuation while in service.

County Campaigns Are Planned For Contributions To AMEF

Presidents of county medical societies have been asked to appoint a person to serve as county chairman for solicitations for the Amedical Medical Education Foundation.

The chairmen will announce the fund campaign at the November meetings of their individual societies, and secure one person on each hospital staff in the county to make an announcement of the drive and pass out subscription cards.

Deans of the two medical schools in the state will also seek support for the campaign through the alumni.

Through the AMEF, funds may be donated to a specific medical school, with the costs of administration supplied by the American Medical Association and not subtracted from the donations.

As of September 1 of this year, Wisconsin has contributed $7,900, which is just $500 more than contributed by the same date last year. $3,500 of this amount has come from Auxiliary units and $3,400 from physicians.

If the 1960 total is to be achieved, some $7,000 more must be raised between September 1 and the end of the year.

Psychiatric Association Plans Milwaukee Meeting

Panel discussions on timely subjects in the psychiatric field plus symposiums on impulses will be included in the program of the Milwaukee Divisional Meeting of the American Psychiatric Association, to be held in Milwaukee Nov. 16–18.

Outagamie Society To Make A Special Study On Ambulance Service

The Outagamie County Medical Society has ordered a study of ambulance services in Appleton and of a possible code of ethics for ambulance operators and attendants.

A three-member committee with Dr. Marvin S. Kagen, Appleton health commissioner, was named to meet with ambulance operators and police officials.

Ambulance operators in the past have been criticized by physicians for making diagnoses and reporting such to the press and radio.

Also criticized was alleged abuse of the red lights and sirens by ambulance drivers.

Outagamie County recently set up minimum standards for ambulance attendants and drivers.

Grant County Society Votes Investigation Of Football Helmets

The Grant County Medical Society has voted to work with the Wisconsin Athletic Insurance Association to investigate football helmets being used by Wisconsin high school football teams.

At a September 28 meeting the Society examined the helmets being used by teams in the Grant County area, as the result of a serious football accident at a game between Fennimore and Boscobel two weeks before.

A 15-year-old was paralyzed as the result of a spinal injury after being hit by a protruding nose guard of a helmet.

The physicians examined the helmets and discussed ways in which they could cause serious injury. In a letter to the insurance organization, the physicians asked that the investigation be directed toward finding the least harmful, yet protective, helmet.

Nursing Scholarships

The Wisconsin State Board of Nursing, at its meeting in Madison October 5, awarded scholarships totaling $12,225 to eight Wisconsin registered professional nurses for advanced educational preparation.

GOOD PRESS RELATIONS was the topic under discussion by Dr. John Heisel, Superior, president of the Douglas County Medical Society, on the left, and Dr. L. H. Lokvam, Kenosha, president of the State Medical Society, on the right. Newsmen from Superior and Duluth were guests of the county medical society September 6 at a meeting to discuss medical-press relationships.

Superior Physicians Successful In Holding Medical–Press Meet

"Your local doctors, the men who are here tonight, are the image of medicine . . . not the false picture being distributed by the Social Security planners in Washington," Dr. Leif H. Lokvam, Kenosha, told a medical-press conference in Superior September 6.

Attending were representatives of newspapers, radio and television in the Duluth and Superior area and physicians from those two cities and Ashland.

Doctor Lokvam, president of the State Medical Society, praised the communications media "for their outstanding performance in expanding public understanding of health and disease problems."

He urged physicians "to make their service one of scientific excellence coupled with full communication cooperation with news media, voluntary agencies and civic groups interested in better health."

He added that the best way for physicians to maintain the respected image of medicine is through day-by-day service as full members of society as well as the practice of medicine.

Serving as chairman of the meeting was Dr. John G. Heisel, Superior. Participating, in addition to area newsmen, was Earl R. Thayer, assistant secretary of the State Medical Society.

As a result of the meeting, several changes are being made by the newsmen and hospitals to make it easier to gather news concerning medicine; the county society is setting up a committee to further press relations, and an annual medical-press conference will be held.

Copies of "A Guide for Physicians, Hospitals and News Media," developed under the leadership of the State Medical Society, were distributed to those attending.

Wisconsin Nurse Named To VA Advisory Group

Miss Helen L. Bunge, associate dean and director of the University of Wisconsin School of Nursing, has been named a member of the Special Medical Advisory Group of the Veterans Administration.

Retiring from the group is Dr. Frank L. Weston, professor of clinical medicine at the University of Wisconsin.

The group meets quarterly in Washington to advise the Administrator of Veterans Affairs and the VA Chief Medical Director on the VA medical program.

Movie Is Now Available On AMA Annual Meet

Medifilm Report III, presenting highlights of the American Medical Association's 110th Annual Meeting in New York City, is now available to medical and allied groups.

The 16 mm, black and white sound film, which runs 33 minutes, features scientific exhibits, lectures and panel discussions.

It is available from the American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois; or Audio-Visual Department, Schering Corporation, Union, New Jersey.

Open Madison School For Medical Assistants

A new school specifically designed to train young women as medical assistants to physicians will open in Madison soon.

Known as Wisconsin School of Medical Assistants, the institution will offer two single-semester courses of instruction each year to high school graduates interested in careers as skilled medical aides in physicians' offices and clinics.

Robert N. Randall, executive director of the new institution which is located in the former Dean Clinic building, has announced that the faculty will consist of 30 instructors and lecturers, including several physicians, registered nurses and registered laboratory technicians.

Among physicians on the faculty are two members of the State Board of Medical Examiners: Dr. Thomas W. Tormey, Jr., Madison; and Dr. William C. Henske, Chippewa Falls.

Team Physicians Are Invited To Athletic Injuries Conferences

Team physicians, coaches and athletic directors will attend five athletic injuries conferences scheduled in various parts of the state Saturday, November 11.

The conferences are sponsored by the Wisconsin Interscholastic Athletic Association and the Charitable, Educational and Scientific Foundation of the State Medical Society.

Meetings will be held that day at Fond du Lac High School, Richland Center High School, Stevens Point State College, Stout State College in Menomonie, and Waukesha High School.

At each site the morning program will be an athletic directors and coaches workshop, non-medical in nature. Starting at 1:15 and continuing to 4 p.m. the program will be devoted to athletic injuries.

Topics covered will be: "Value of Training and Conditioning," "Emergency Care in Athletics," and "Limitations on the Care of Injured Athletes by Coaches."

Speakers at the five sites will be:

WAUKESHA: Dr. Bruce Brewer, Milwaukee; Dr. J. C. H. Russell, Fort Atkinson; and Dr. Paul Campbell, Waukesha.

FOND DU LAC: Dr. Ewald Pawsat, Fond du Lac; Dr. Donald McCormick, Fond du Lac; and Dr. J. L. Weygandt, Sheboygan Falls.

STEVENS POINT: Dr. F. W. Reichardt, Stevens Point; Dr. Alber J. Molinaro, Wausau; and Dr. Roy Larsen, Wausau.

RICHLAND CENTER: Dr. William H. Bartlett, Madison; Dr. H. W. Carey, Lancaster; and Dr. Dayton Hinke, Richland Center.

MENOMONIE: Dr. Charles Ihle, Eau Claire; Dr. Max Bachhuber, Alma; and Dr. Thomas E. Kilkenny, Eau Claire.

New Appointment Made By Welfare Department

The State Department of Public Welfare has announced the appointment of Robert H. Lizon as assistant director of the Division for Children and Youth.

The division operates a foster care and adoption program involving approximately 2,700 children and also licenses voluntary child welfare agencies, assists counties in strengthening child welfare services, and helps communities improve services to children and youth.

Hypnosis Is Not Entertainment General Practitioners Are Told

"Hypnosis is not foolishness nor is it some kind of parlor game or entertainment," Dr. Robert F. Purtell, Milwaukee, told members of the American Academy of General Practice September 20. "It is worthy of increased scientific study."

Doctor Purtell reported success in the use of hypnosis to reduce the quantity of drugs administered during the first stages of child labor.

He concluded his report with a plea for better control of hypnosis in medicine, more serious case studies in the field, and better training by medical schools in the use of hypnotism as a professional tool.

At their annual dinner, members of the Academy heard Dr. Edward R. Annis, Miami, Florida, urge them to "get the other side of the medical care story before the people" to forestall the administration's program of providing health benefits under Social Security.

"We're not trying to put anything over on anyone," he said. "We just want to bring the facts to the people so that someone else doesn't put something over on them."

Doctor Annis said that the American people must be told that:

Medical care is expensive because it is good.

Most Americans pay more for automobile insurance than for complete medical care coverage.

If physicians continue to "aid and encourage the American people to abuse medical insurance," it will become too costly to buy, he concluded.

Members of the Academy passed a resolution urging the state legislature to pass enabling legislation to implement the federal Kerr-Mills law.

Honor Charles Pollock For 33 Years' Service

Charles Pollock, Madison, was recognized for 33 years of service to the *Wisconsin Medical Journal* upon his retirement from the sales department of the Democrat Printing Company in September.

Pollock had worked closely with the State Medical Society for over three decades in the production of the *Journal*. He was presented with a folder, a facsimile of the *Journal*, which contained the best wishes of the Society.

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History and Management of Epilepsy in Wisconsin

By EDWARD D. SCHWADE, M. D., and JEAN P. DAVIS, M. D.

Milwaukee, Wisconsin

EDITOR'S NOTE: Doctor Schwade died on November 4, 1961. This article, recently completed, is being published as a final contribution from a physician who devoted tireless hours to the inprovement of public understanding of epilepsy.

EPILEPSY is not endemic to Wisconsin nor is Wisconsin a haven for the epileptic. However, the state of Wisconsin has been a pioneer in the management of the epileptic. Many volumes have been written about epilepsy in the past and many articles have appeared in medical and lay magazines on the many facets of the condition. The purpose of this article is to draw attention to what we have accomplished during a 25-year span in the field of epilepsy, what is being done, and what is projected for epilepsy in the future.

Epilepsy is among the earliest diseases described. Mention is made of the "falling sickness" in the Old and New Testaments, and the "sacred disease" in Greek literature. It is said that Socrates, Alexander the Great, Julius Caesar, Mohammed, Dostoievsky, Byron and Van Gogh had epilepsy. However, it is much more important to know that the average man or woman, boy or girl, famous or infamous, genius or dullard, may develop epilepsy at any stage in life.

That the incidence of epilepsy in the population is high is attested to by the experiences of both world wars. The U.S. Surgeon General[1] reported that "epilepsy, next to schizophrenia, was the most frequent cause for discharge from the Army." In 1929, Bailey, Williams and Kamora[2] stated that 5.15 per 1,000 of those examined by draft boards were rejected because of epilepsy. One must remember that children who have epilepsy, patients in hospitals, and individuals who do not report their condition are not included. To summarize, the incidence of epilepsy in the total population is much higher than most would think—certainly higher than many other highly publicized chronic diseases. It was this awareness that prompted us to see what we could do about epilepsy and the epileptic.

The neurophysiologist in his laboratory had been hard at work trying to find the causal mechanisms of seizures—and making steady and dramatic progress. By 1938, Hans Berger, clinical electroencephalographer, published his observations and interpretations on the electroencephalogram. In 1935 Gibbs, Davis and Lennox[3] began recording the electroencephalogram in epilepsy, and

Grey Walter[4] showed that brain tumors could be localized by the electroencephalogram through the unopened skull. The voluminous works published by Adrian, Bailey, Barnes, Bishop, O'Leary, Erlanger, Gasser, Sherrington, Brazier, Davis (H. and P.A.), Gastaut, Lennox, Gibbs, Jasper, McCulloch, and others in the field of neurophysiology were the motivating forces in our attempt to piece together the total problem of the epileptic. Dr. William Lennox and Dr. and Mrs. Frederic Gibbs were our inspiration, and gave so much of themselves that we feel grateful to them for whatever we have been able to accomplish in the state of Wisconsin.

Prior to the second world war, in 1938–1939, epileptics were followed in the neurological, pediatric or psychiatric service at the Milwaukee County (Hospital) Dispensary. The "depression days" were still at a high and most patients came solely for drugs —there was no thought at that time of a specialty clinic for epilepsy and related disorders. During the war years, many epileptics enlisted, but with their first seizures, they were discharged, only to come back to a society which did not understand the reason for their not being in service. Many employers would not accept them. The epileptics felt this discrimination and did not disclose their problems, which created a vicious cycle.

First Epilepsy Clinic in Milwaukee

At the end of World War II, we established the first clinic for epilepsy at the Milwaukee County Hospital Dispensary, and serviced only patients in Milwaukee County. Much stress must be placed on the work of Dr. M. G. Peterman, who did a great deal of research at the Mayo Clinic on the ketogenic diet prior to coming to Milwaukee. Doctor Peterman has been vitally interested in children who have epilepsy and has contributed to the literature on the metabolic disturbances in epilepsy.[5, 6] He, too, encouraged the development of an epilepsy center at the County Hospital Dispensary. During the years at the Milwaukee County Dispensary we began our many-pronged attack on the problems of care for the epileptic—better diagnosis,[7, 8] more effective therapy, and changes in the social climate, so that these people, young and old, could establish a more wholesome life in the future.

With the establishment of the Milwaukee County Dispensary away from the metropolitan area of Milwaukee, the Variety Club of Wisconsin, which had been interested in our previous project, decided to sponsor a total epilepsy program at Mt. Sinai Hospital. This became a fact in 1956. One of the authors, who had been at Columbia Presbyterian Medical Center in New York, became director, and the other took charge of the electroencephalographic laboratory and served as consultant to the clinic.

Since the inception of the Variety Club Epilepsy Center in 1956, more than 500 patients have been examined and placed on therapy. The only requirement for admission to the Center is referral by the patient's private physician. There are no restrictions as to age, race, religion or residence. The clinic staff includes: neurologist, psychiatric consultant, social worker, clinical psychologist, electroencephalographers, and secretarial help. Laboratory and x-ray facilities and the pharmacy of the hospital are available for services to the Center.

Staff conferences are held regularly each week to discuss the various problems of the patient and to work out a continuing plan of treatment based on the individual's needs. This also affords teaching for interns and residents of the hospital. Frequently case workers, teachers, probation officers, psychologists, nurses, and physicians attend these weekly staff meetings.

With this introduction we would like to present a graphic picture of what the physician should know concerning all phases of the management of the epileptic.

Management

We will not attempt to discuss the various types of epilepsy. We feel, with Lennox,[9] that "to call epilepsy a symptom lends support to the chronic cry of 'epilepsy, the inscrutable, the unknown,' and the word cryptogenic, born of secrecy, means frankly 'I don't know.'" In many persons subject to seizures, both an inherent tendency and a damaged brain seem responsible. Therefore, using a legal phrase, epilepsy is a disease entity and/or symptom. We feel that epilepsy is a disease as much as diabetes, obesity, cancer, nephritis, and arthritis are diseases. We know more about the cause of epilepsy than we do about many other diseases for which the complaint of "unknown" is seldom raised.

PATIENT CASE LOAD BY AGE AND SEX DURING A FIVE-YEAR STUDY BY THE VARIETY CLUB, MT. SINAI EPILEPSY CENTER (FIG. 1, 2 AND 3)

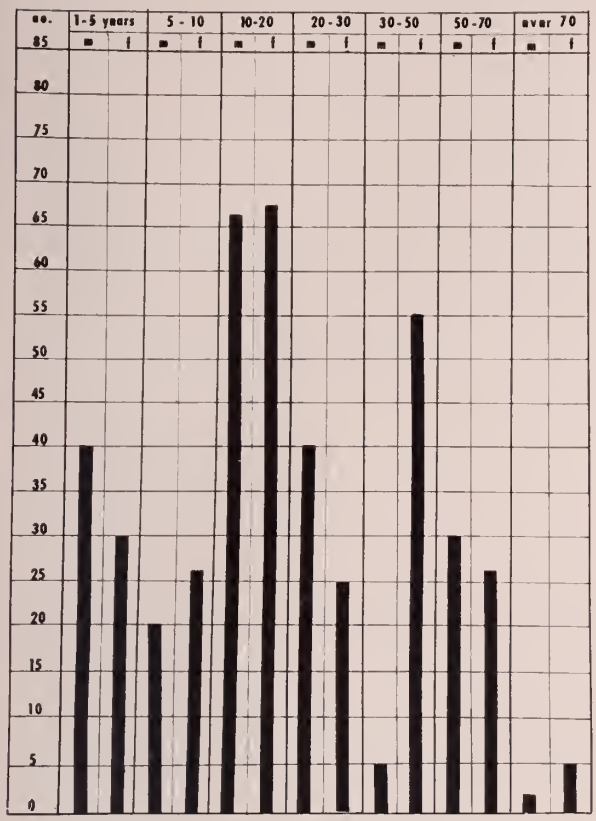

Fig. 1—Patient case load by age and sex.

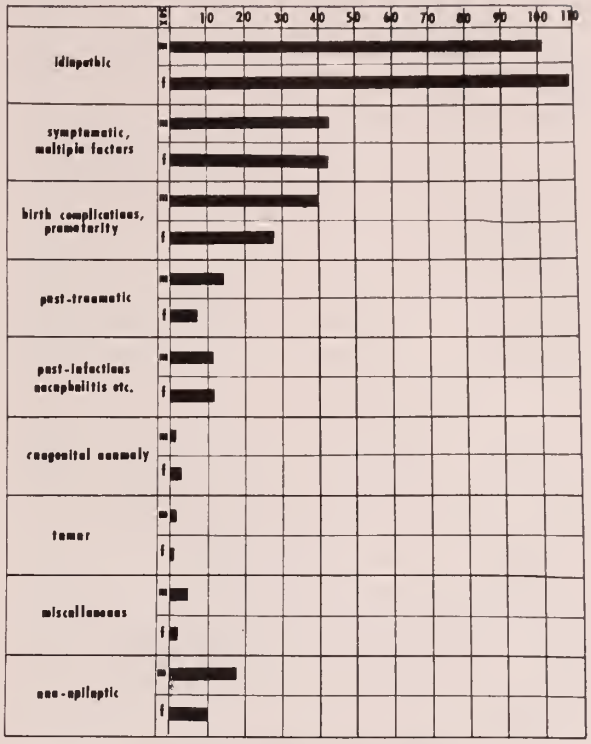

Fig. 2—Etiology of seizures.

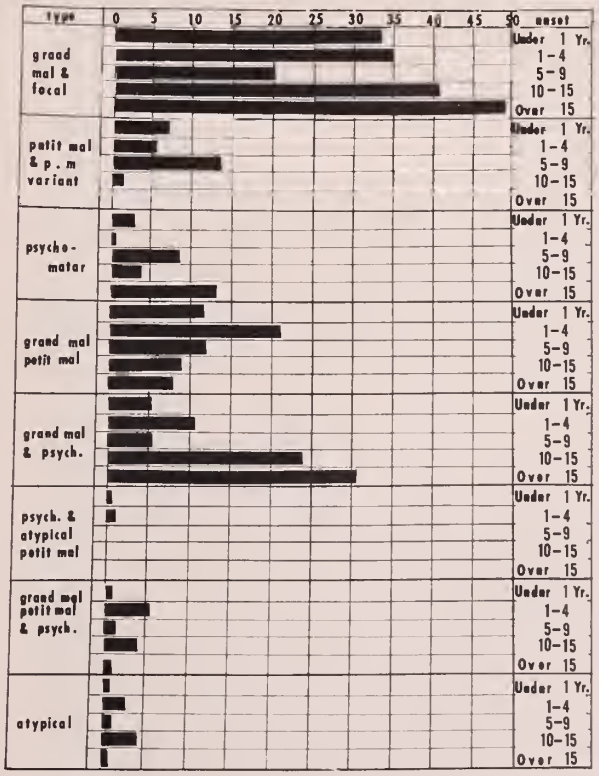

Fig. 3—Patient case load by seizure type and age of onset.

Diagnosis

Very rarely does a physician see the patient in an attack; he sees the patient postictally—drowsy or confused. The detailed history of the first seizure and the relative frequency and variations of subsequent attacks are extremely important in establishing a diagnosis. With the exception of some focal or psychomotor seizures, the patient does not have recall for the attack. Thus, it is of great assistance to have a relative or close friend help in presenting the history. The familial history of nervous or mental disorder is an aid in indicating an epileptic tendency. The history of the pregnancy and the perinatal period helps to establish the possibility of developmental anomalies or early trauma to the brain. The history of acute febrile illnesses, especially the exanthemata and possible complications suggestive of associated encephalitis are very important. Has the patient had any head injuries—were there headaches or other com-

plications? It is very important to know his general health. In females, one needs to know the relationship between menses and seizures, which may help in later management. We need to know the patient's developmental history. At what age did he walk and talk? Was he eneuretic? Many children having brief seizures present only a history of eneuresis. The physician should know of the patient's scholastic level in proportion to his chronologic age.

The physician should assess the personality of the patient, his adjustment to his problems, and the attitude of other members of the family. Conflicts may exist between man and wife—child and parents—patient and peers or siblings.

Finally, in history taking, the physician should learn what previous medical care the patient has had, including the medication he has taken and possible allergies he has had to drugs. Has he been using the medication faithfully? Is he careless? What is his attitude to taking it for many years? Is he cooperative? A history of alcoholic habits is pertinent, since alcohol might be a cause of seizures.

In the instance of grand mal epilepsy, a scarred tongue or scars in the buccal membrane together with paroxysmal spiking in the electroencephalogram are confirmatory signs of such diagnosis. The first seizure may very often be an isolated attack, and then years may pass between the first attack and the subsequent seizures. It is quite significant that the physician consider any attack in childhood as a serious problem. It is not necessary to inject fear, but intelligent discussion with the family is extremely helpful.

A thorough physical and neurological examination is essential. The average epileptic usually fails to show positive neurologic findings.

Electroencephalography

Next to the detailed history, the electroencephalogram is the most important feature in arriving at the diagnosis of epilepsy. In 75 to 85% of those with seizures, the electroencephalogram is confirmatory. A normal record only provides negative and presumptive evidence. We feel that sleep is an effective method of activation. Seconal or chloral hydrate will induce sleep and the discerning electroencephalographer will recognize abnormalities which might occur during the sleep recording. Occasionally pentylenetetrazol (Metrazol) in small doses is used for activation.

During the past 14 years, we have been carefully studying the patterns of electrical

Fig. 4—Paroxysmal spike and wave (high amplitude) —classical petit mal.

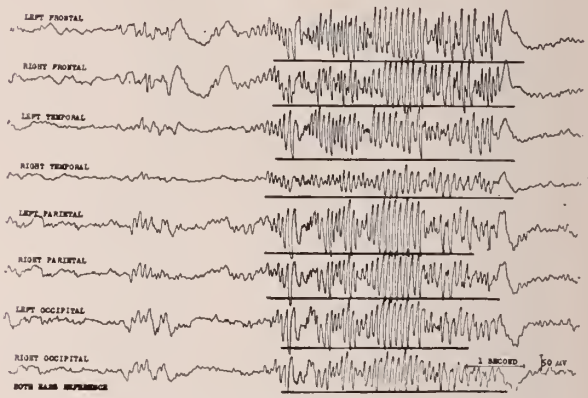

Fig. 5—Paroxysmal high amplitude spiking, classical of grand mal—sleep recording.

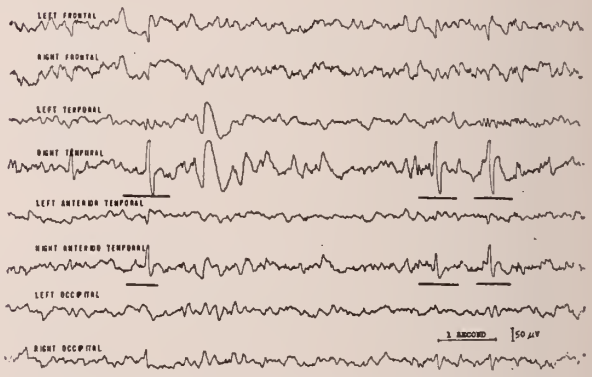

Fig. 6—Diphasic high amplitude spiking in the right temporal spreading to the right anterior temporal which is classical of temporal lobe epilepsy.

(Significant discharges are underscored.)

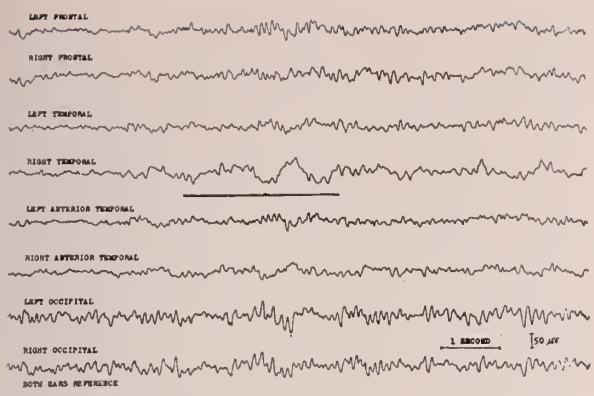

Fig. 7—High amplitude slowing confined to the right temporal area which was persistent throughout the entire record. This is consistent with focal type of lesion. (At operation the neurosurgeon removed right sphenoidal ridge meningioma.)

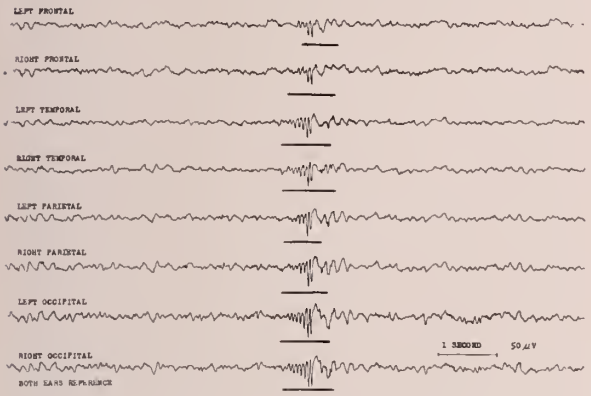

Fig. 8—Fourteen per second positive spiking.

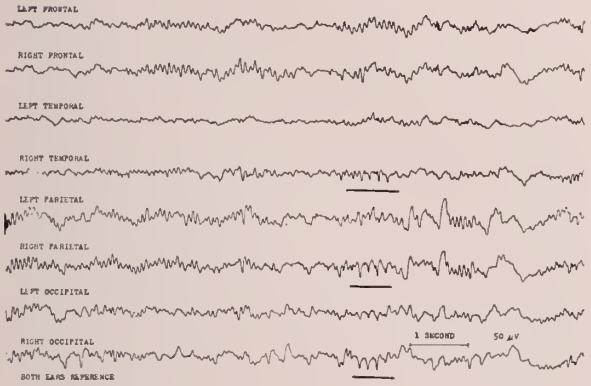

Fig. 9—Six per second positive spiking right temporal, right parietal, right occipital.

(Significant discharges are underscored.)

activity in the borderlands of epilepsy. Much of our time has been devoted to the 6 and 14 per second positive spiking which occurs in certain severely disturbed young people.[10-13] We have investigated the correlation between the clinical history and electroencephalographic patterns in the spike and wave dysrhythmias.[14] We have been observing dysrhythmias in some patients with refractory diabetes. We are also trying to correlate the seizure of alcoholism and various patterns in the electroencephalogram.

In our laboratory, we make use of photic stimulation by means of a stroboscope. A range of 3 to 20 flashes per second for periods up to 10 minutes is used to evoke discernible photic driving or paroxysmal responses.

Pneumoencephalography and arteriography are necessary only when the physician feels that there is a space-occupying lesion or some cerebral vascular disorder such as angioma, aneurysm or displacement of blood vessels by tumors. This should only be done when it is necessary in the physician's mind to rule out such conditions.

In general, the patient with epilepsy has about the same range of intelligence as the average population. If there is any question, psychological evaluation should be obtained. It would be helpful to the psychologist and school authorities to know whether the patient is over-sedated, or mental dulling is part of the underlying condition.

Treatment

The treatment of epilepsy is essentially medical. The following are well-established medications:

1. *Phenobarbital.* Without exception phenobarbital has been the neurologists' and psychiatrists' most important anticonvulsant and sedative since its introduction in the early 1900's. Prior to diphenylhydantoin sodium (Dilantin sodium), it was the only safe and effective drug in the field of convulsive disorders. It is still the safest medication in all of the armamentarium of the anti-epileptics. In itself, it will probably not control all types of epilepsies. Nevertheless, it is a mainstay in the treatment of epilepsy. It is used safely with any of the newer anticonvulsants and for all types of epilepsy. Phenobarbital is nontoxic except in large doses when it may produce over-sedation or somnolence. Occasionally a rash may occur in drug-sensitive patients. We have never seen phenobarbital produce blood or liver damage.

2. *Mephobarbital* (Mebaral) is a barbiturate which may be useful in any of the epi-

lepsies and is generally less sedative than phenobarbital. Large doses may be somnolent. Mephobarbital is a relatively nontoxic drug, but like phenobarbital it very occasionally produces a rash. No blood dyscrasias are noticed even in large doses. The range of dosage is .03 gm. to 0.1 gm. three to four times daily, given alone or combined with other anticonvulsants.

3. *Diphenylhydantoin sodium* (Dilantin sodium), which comes in a sealed capsule with a pink, orange, red or black band to denote the dosage and combinations, is an excellent anticonvulsant. Merritt and Putnam first introduced diphenylhydantoin sodium in 1940. Actually, this was the first anticonvulsant made available since phenobarbital and its derivatives. It is most useful in grand mal epilepsy and with other combinations is effective in psychomotor seizures. It is of little value in petit mal. Most of the toxic side effects are relatively simple and can be overcome with alteration of the dosage. Gum hypertrophy may be troublesome, but not dangerous to teeth. In overdoses, diphenylhydantoin sodium will produce symptoms of cerebellar nature, such as nystagmus, double vision, staggering, and ataxia. The drug has very little hypnotic effect which makes it desirable. Doses of .03 gm. to 0.1 gm. three or four times a day will produce few, if any, side effects.

4. *Methylphenylethyl hydantoin* (Mesantoin) is another hydantoin product which was introduced especially for psychomotor attacks. The adult dosage is 0.1 gm. three to five times daily. It is an excellent drug for grand mal but has less effect on petit mal. Frequently it is useful in the akinetic type of seizures in elderly patients. It must be remembered that the drug may produce bone marrow depression—blood counts must be followed. The great advantage over diphenylhydantoin sodium is that it causes little gum hyperplasia, rarely produces cerebellar symptoms, and does not produce hirsutism. Methylphenylethyl hydantoin may give rise to drowsiness. Occasionally an itching morbiliform type of rash develops. In all instances, we examine the blood since there is a tendency to hypochromic anemia and in a few instances it has produced aplastic anemia. It is always advisable to take the patient's blood count prior to starting medication and follow it repeatedly after the patient has taken the drug at monthly intervals. If the white blood cell count drops below 3,000, it may be advisable to stop the medication and replace it with another anticonvulsant. As with all anticonvulsants, the drugs should be given in minimum doses at first and increased until the attacks stop. With adequate blood counts taken regularly, methylphenylethyl hydantoin may be used for many years.

5. *Phenacemide* (Phenurone) is a very valuable drug in the hands of people who understand the product. It is most useful in psychomotor and grand mal epilepsies, and in combination with other drugs it is very often effective in petit mal and akinetic seizures. It is also effective in symptomatic seizures in childhood. We have used the drug since its original investigation and found it very useful, provided the patient understands the nature of complications. In doses of 0.25 gm. to 1.0 gm. per day, if watched carefully for any side effects, the drug is a valuable aid in therapy. Gastrointestinal upset, general malaise and fever may be indicative of early liver damage or blood dyscrasias. Phenacemide may produce irritability and paranoid tendencies. These are warning signs of an untoward reaction. If these are detected early and the dosage is reduced or phenacemide is discontinued, the condition is reversible. Blood counts and liver function tests should be taken regularly while the patient is on phenacemide.

6. *Ethotoin* (Peganone) is a synthetic hydantoin which has been studied by the authors for a number of years.[15] This drug is an excellent anticonvulsant which is most effective in grand mal seizures and to a lesser extent in psychomotor seizures. Ethotoin is compatible with all the commonly employed anticonvulsants, and is the least toxic of the hydantoins studied to date although it may be slightly sedative. It very infrequently produces gum hyperplasia, cerebellar symptoms, hirsutism, rash, or blood dyscrasias. It is our experience that when ethotoin is effective, other anticonvulsants may be decreased.

7. *Primidone* (Mysoline) is an effective anticonvulsant for the control of grand mal and psychomotor seizures. It has little effect on petit mal and akinetic seizures. As with other anticonvulsants, blood studies should be followed. We have had several cases of severe hypochromic anemia and two cases of aplastic anemia following the administration

of primidone. It is advisable to start with very small doses and increase gradually until seizures are decreased or stopped. Other side effects are drowsiness, weakness, ataxia, mental dullness, nausea and headache.

8. *Trimethadione* (Tridione) is used in the treatment of petit mal, myoclonic and akinetic epilepsy,[16, 17] and is particularly valuable in children. Satisfactory management of akinetic epilepsy may require the combination of trimethadione with other anticonvulsants. The drug should be used with great care if the patient has both grand mal and petit mal attacks since it may aggravate grand mal attacks. The dosage is from 0.9 gm. to 2.1 gm. in three or four divided doses each day. It is well to start with smaller doses and increase until the attacks become infrequent or disappear. Blood counts should be taken periodically since there is a tendency for trimethadione to cause neutropenia or aplastic anemia. Occasionally sensitivity toward trimethadione may also result in a morbiliform rash which also necessitates withdrawal of the drug. Hemeralopia occurs in the course of treatment with trimethadione but is usually mild, and lessened satisfactorily with the use of dark glasses.

9. *Paramethadione* (Paradione), a close congener of trimethadione, is valuable in the treatment of petit mal and myoclonic seizures. Frequently when trimethadione does not effectively control petit mal, paramethadione is successfully substituted and vice versa.[18] Symptomatic, atypical petit mal, myoclonic, and akinetic epilepsy associated with brain damage may be effectively controlled by paramethadione. Paramethadione is more sedative than trimethadione, but untoward reactions occur less frequently. A total of 0.9 gm. daily in divided doses is usually adequate. The dosage can be increased or decreased depending upon the response of the patient or upon the occurrence of undesirable side effects. Blood counts should be followed, as with trimethadione.

10. *Methsuximide* (Celontin) and *phensuximide* (Milontin) are anticonvulsants of the succinimide family, and are mentioned here as useful in the treatment of the petit mal triad when any of the foregoing anticonvulsants are not entirely effective. Our experience with methsuximide and phensuximide has demonstrated that these two preparations are not as effective as the drugs previously mentioned, and the dosage may be limited by their sedative effects.

11. *Ethosuximide* (Zarontin) is the most recently developed member of the succinimide series. Our clinical experience with 30 patients indicates that this is the most specific and effective member of the series against petit mal, and that it is less sedative than the other congeners. The average dosage is 0.25 gm. three to four times daily, although some patients may require up to six capsules daily. Periodic blood counts and routine urinalyses should be followed.

12. *Chlordiazepoxide* (Librium) has been used by the authors since the early part of 1960. We feel that in a number of children with petit mal the drug has been effective in combination with other anticonvulsants. Most important however, is the fact that chlordiazepoxide has been very effective in the control of fear, anxiety and tensions as the result of apprehension of future attacks. Having an anticonvulsant effect, and lessening the anxiety and tensions of epileptics, this drug is very useful in all types of epilepsy in combination with other anti-epileptics. In large doses it might become sedative. In children we have used 15 mg. per day and in adults up to 100 mg. per day. We have used larger doses in children who have behavior disorders associated with the syndrome of 6 and 14 per second positive spiking with good effects.

13. *Acetazolamide* (Diamox) is an effective diuretic, the action of which depends upon the inhibition of carbonic anhydrase in the renal tubules. It is active in mobilizing edema fluid resulting from congestive heart failure, toxemia or edema of pregnancy, and in the reduction of intraocular tension in glaucoma. It has been used effectively in epilepsy, particularly in the petit mal triad, or in the relief of attacks in women associated with premenstrual tension and edema. Whether its effectiveness in epilepsy is only diuretic, or whether it has a more specific role, in the direct inhibition of carbonic anhydrase in the brain, has not been clearly established although the latter seems to be a factor.[19] We have found acetazolamide an effective aid in almost all the epilepsies, especially in women. In conjunction with other anticonvulsants, we have used 0.375 gm. to 1.0 gm. per day in divided doses. One should be extremely cautious in increasing the dose

of acetazolamide since large doses do not necessarily increase the diuresis and may produce drowsiness, vertigo, and paresthesias. It is also well known that the drug is contraindicated in patients with any type of adrenal disease. In general, it is advisable to limit the fluid intake in any type of epilepsy.

The type of dysrhythmia in the electroencephalogram is sometimes extremely helpful in the choice of therapy; e.g., paroxysmal slow wave activity or a petit mal pattern in the face of clinical grand mal may indicate increasing benefit from the addition of small doses of anti-petit mal medication.

Surgical extirpation of epileptogenic foci should be reserved for patients whose seizures have proven refractory to medication, after extensive trial on all established combinations in full dosage.

Comment

When the diagnosis of epilepsy is made and the proper medication is afforded to the patient and the attacks subside or become controlled, only half of the treatment is accomplished. The physician should be aware that the epileptic has had many psychologically traumatic experiences. We must recognize the fact that frustrations and anxiety might trigger off a seizure when least expected. One hears too often the words "epileptic personality." This is the result of ignorance and misunderstanding of epilepsy. It is imperative that the physician should spend some time with the epileptic discussing his social and economic problems with a great deal of understanding. It is advantageous to discuss the situation with the family so that they, too, will have better understanding of the nature of epilepsy.

The authors feel that the most important aspects of study in epilepsy should be concentrated on more specific and effective medication. They have conducted investigative studies in this field for many years. Such research involves a great deal of painstaking work. In addition to evaluation of clinical results this requires understanding on the part of the patient and family. Detailed laboratory work is necessary including urinalyses, complete blood counts, periodic liver function tests, evaluation of thyroid activity, blood chemistries and electroencephalograms. The most recent anticonvulsant study by the authors is 3-ethyl-5-isobutyl-2-thiohydantoin (Bax 422) which has been used to date in approximately 100 patients over the past three years.[20]

A seizure is not in itself a cause of death. The only cause for death directly related to epilepsy is the condition of status epilepticus. As applied here, this consists of a series of convulsions recurring at short but irregular intervals, accompanied by continuous unconsciousness. Death results from exhaustion, alteration of the electrolyte balance, or secondary infection. Even this condition may be overcome, if treated promptly and adequately. Intravenous therapy is preferable to the intramuscular route of administration. The authors prefer sodium pentothal, 1 gm. in 1,000 cc. of 5% glucose solution by the drip method, which can be interrupted upon cessation of the convulsive activity. The existence of petit mal and psychomotor status is also recognized, but these do not carry the serious import of grand mal status.

The thesis that the epileptic under adequate medical control is substantially no greater a mortality risk than the average normal person is a hopeful fact to describe to the patient and his family. Otto and one of the authors[21] made a study of the partial classification of deaths in Wisconsin in 1953, which supports this premise.

The education and rehabilitation of the epileptic has received a great deal of study and attention in the state of Wisconsin. In many areas of the United States the epileptic child is excluded from regular public school classrooms upon the recognition of attacks. Educators in Wisconsin have provided for the epileptic child who has no other disabling conditions and whose attacks are moderately or completely controlled. The authors have worked with special services in the public school systems in the State and have met with them on numerous occasions and found willing support. If a child's attacks are not controlled, homebound training is provided as long as necessary. Our school system recognizes that it would be detrimental to continue homebound training with moderately and completely controlled epileptic students, since this isolates the child; and the tendency to develop hostile and aggressive attitudes toward society results in the so-called "epileptic person" by virtue of this isolation. As a result of this thinking, a pamphlet was prepared entitled "The Epileptic Child in Your School"[22] as useful information for school administrators, classroom teachers,

physical education instructors, welfare, guidance and psychological counsellors, as well as health personnel who offer service in school health programs. The authors have had many conferences with educators in high schools, colleges and universities, and as a result there has been little discrimination against the epileptic in fields of higher education.

Rehabilitation

That epilepsy is not a disabling disease when it is completely controlled has been recognized for a long time by the Rehabilitation Division of the Wisconsin State Board of Vocational and Adult Education. The Rehabilitation Division has been of tremendous help[23] in including the epileptic in its rehabilitation program. Many young people throughout the state who have never had opportunities for education beyond grade school have been afforded advanced education or vocational training, along with careful neurologic examinations, electroencephalograms, and therapeutic sessions with specialists in the field who have controlled their attacks so as to make employment possible.

Through the American Medical Association we have been on a Committee on Neurologic Disorders in Industry[24] and assisted in developing a guide to classification and employment of persons with neurologic disorders. We have tried to classify the neurologic disorders somewhat after the heart classification. While the current guide of classification and employment of persons with neurologic disorders is not perfect, it is a step in the right direction. The fact that it was approved by the Council on Occupational Health of the American Medical Association was another step forward in accepting the epileptic for employment.

The progressive rehabilitation and research which has been done and is being done for the epileptic could not have succeeded without the whole-hearted support of the State Medical Society of Wisconsin. A great need existed to emancipate the epileptic from iron-clad, antiquated laws. These were archaic and hampered any medical or social progress. Early in 1948 and 1949, we appeared before the Council of the State Medical Society presenting the case for the epileptic. With the consent of the State Medical Society, we launched a massive attack on the discriminatory laws which in effect prevented many epileptics from coming to physicians for help:

1. *The epileptic driver.* From 1929 it was unlawful for an epileptic to operate a motor vehicle in Wisconsin. The law stated in effect, "It is unlawful for any one of the following to operate a motor vehicle upon any highway of this State: . . . a person who is subject to epilepsy . . . " In 1945 at the request of the Motor Vehicle Department, the Wisconsin Legislature enacted a section which provided that "The Department shall not issue any license hereunder . . . to any person subject to epileptic seizures." Except through a voluntary disclosure of an applicant for a driver's license that he had epilepsy, the Motor Vehicle Department had no effective means of determining the presence of epilepsy among licensed drivers in this State. In view of this fact, a bill was passed[25] by the Legislature in 1947 which in effect required reportability of epileptics by local boards of health, city health commissioners, and physicians in the State of Wisconsin. The Motor Vehicle Department upon receipt of such information was required to revoke or refuse issuance of a driver's license to the reported individual. It made no difference whether the epileptic was controlled or not. We were certain that most epileptics would not report their condition on the application. Many persons who had epilepsy did not come to the physician for help since they suspected that the physician might report it to the local health authorities or the Motor Vehicle Department. If this were so, highway safety was being retarded rather than advanced by reason of the reportability laws and failure to grant licenses to epileptics who were completely controlled.

Armed with legal counsel from the State Medical Society and with the able assistance of Dr. Edward Roemer of Madison, Wisconsin, we convinced the Wisconsin Legislature to accept a machinery for the issuance of a temporary driver's license for epileptics upon medical certification. The law provides that any epileptic who is completely controlled for two years or more may obtain a "normal" driver's license upon such certification by a licensed physician. These licenses are renewable every six months with recertification by the physician. If the epileptic is completely controlled for less than two years but more than one year, he can appeal to the Motor Vehicle Department to appear before

a Medical Review Board. The Medical Review Board consists of two physicians and one or two members of the Motor Vehicle Department. Upon the approval of the Medical Review Board, the Motor Vehicle Department will issue a license to the epileptic. This information is always kept confidential. At the Board hearings, the applicant is present, and the Board takes into consideration the epileptic's attitude, behavior, age, coordination, and the certification of the physician who has attended the patient. In some instances the Board will recommend a limited area license.[26]

At present, our most enthusiastic participant in the Motor Vehicle Department is Mr. John W. Thompson, director of the Driver Control Division. He reports[27] since May 11, 1949, the number of licensed drivers in the State has increased from 1,450,585 to 1,936,-636 through 1959. In that same period, accidents have averaged between 50,000 and 55,000 individual accidents per year, involving an average of between 85,000 and 90,000 individual drivers. The percentage of persons who have been subject to epileptic seizures who have been involved in accidents was 8.4%, while .33 of 1% were involved in accidents due to seizures. Medical certification leading to drivers' licensing in the State of Wisconsin has been highly successful. Prior to the passage of the new drivers' licensing law, an epileptic rarely stated that he had epilepsy on the application form. In a 10-year period, 1,561 persons reported that they were subject to attacks on the medical form. Since 1949, several insurance companies have offered risk types of insurance and we have no difficulty in getting automobile insurance for any of our controlled epileptics. During the past 11 years, the attitude toward the epileptic has been much more wholesome and the epileptic's attitude toward his physician has been more confident.

2. *Marriage and the Epileptic.* In 1907, Wisconsin made it a crime for an epileptic person to contract marriage. The Wisconsin statutes provided, "No man or woman, either of whom is an epileptic, shall marry." (A fine or imprisonment was provided for violators.) This was repealed in 1927 but previously, in 1917, the Legislature had included the epileptic among those considered incapable of contracting marriage. From 1917 until 1953, the statutes provided that "no insane, imbecile, feeble-minded or epileptic person or idiot shall be capable of contracting marriage." We were able to demonstrate[28] to the Wisconsin Legislature with the help of the State Medical Society of Wisconsin that the epileptic person was capable of contracting marriage and that the condition was not directly transmissible. A bill was introduced by the State Medical Society in the 1953 session of the Wisconsin Legislature which struck the term "or epileptic person" from the provision of the Wisconsin statutes.

3. *The commitment to and treatment of the epileptic in public institutions.* For too many years the epileptic was classified with the mentally diseased under the Wisconsin Mental Health Act and was subjected to the same commitment procedures and restraints. In 1955, the Wisconsin Legislature was convinced through the efforts of one of the authors and legal counsel for the Medical Society that an epileptic uncomplicated by mental illness or mental deficiency is a perfectly healthy, normal person who is subject to seizures. That year *any* reference to the epileptic in The Mental Health Act was deleted. Many epileptics were incarcerated in our colonies for the mentally retarded. Some epileptics who were not insane were in mental hospitals. It is impossible to describe how much distress it caused personnel in the colonies and the mental hospitals to release these people into society. They had to be supported by their families and afforded treatment. The Rehabilitation Division came to the fore and was extremely helpful in supplying aid to these patients. At the present time, there is *no discrimination* in the Wisconsin statutes against the epileptic.

Life insurance for the controlled epileptic upon certification is available. We have written most of the major insurance companies in the United States and many of them will accept the epileptic with certification of control. Health and accident insurance remains difficult to obtain.

It is suggested that every physician and every prospective employer and every worker in the field of the handicapped obtain a brochure entitled "Society and Seizures."[23]

It is hoped that this paper has demonstrated what has been and is being done, and what the future holds for the epileptic.

In the final analysis, epilepsy must be considered a medical disorder. Whether it is a disease or a symptom complex matters lit-

tle. It is not to be confused with a mental illness. It is disabling only during the attack and for a short time thereafter. It cannot be regarded as totally disabling, nor can it be looked at as a permanent disorder. The "drama" of the seizure should be looked upon as an electrical phenomenon—the light goes off abruptly—or it may only flicker—but always the light returns. The outlook for epilepsy is extremely hopeful. We know of no cure today. We hope for a cure tomorrow. We look upon epilepsy as upon diabetes—both disorders are metabolic, both are controllable. Neither is curable to date. With continued research, we hope that all epileptics will be completely controlled. With better understanding, we hope that all of our children who have epilepsy will be able to complete their education. We are certain that with better understanding of its nature and causes epilepsy will be taken out of the disabling diseases.

(J.P.D.) 312 East Wisconsin Ave.

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SKIN CANCER

J. Murray Riddell, Jr., assistant clinical professor of dermatology, University of Texas Southwestern Medical School, Dallas. Excerpt from *Texas State Journal of Medicine,* July 1961, page 590.

Three hundred white patients with skin cancers were studied. There were almost twice as many men as women in the series. Basal cell carcinomas were almost four times the number of squamous cell carcinomas.

The most striking difference was the large number of tumors on and about the ears of the men (45) in comparison to those (2) in the women. Nine squamous cell carcinomas were seen on the vermilion of the lower lip in men and none in women. There is the impression that more men have more skin cancers and develop these on the average earlier in life than do women.

It is possible to make a clinical diagnosis of cancer of the skin in a high percentage of cases.

Water and Electrolyte Balance

By HENRY BROWN, M. D.

Madison, Wisconsin

A REVIEW of the principles of water and electrolyte balance is in order from time to time to clarify thinking about this important but controversial subject. The following are a few fundamentals which may be used as guides in the practice of surgery.

The human body is composed of about 70% water.[1] This has been determined by direct chemical analysis (combustion), or by indirect measurements such as the distribution of antipyrene, deuterium oxide, or tritium oxide in the body. In indirect measurements corrections are made for body fat content since fat contains a relatively small amount of water.[2]

The body of a lean man weighing 80 kg. would contain about 56 liters of water. Of this about 20% of the body weight, or 16 liters, would be extracellular, as measured by the distribution of injected mannitol of inulin.[2] Fifty per cent of the body weight is intracellular water. The extracellular fluid (ECF) is further subdivided into (1) the plasma compartment and (2) the interstitial fluid.

The plasma compartment is about 5% of body weight, 4 liters, or 50 ml. per kg. of body weight. The plasma volume is determined by dilution measurements with Evans blue dye, radioactive iodine (I^{131}) labelled serum albumin, or radiochromium labelled red cells.[3]

The interstitial fluid, 15% of body weight or 12 liters, is the difference between the total extracellular fluid and the plasma volume.

The intracellular fluid (ICF), 50% of the body weight or about 40 liters, is the difference between total body water and extracellular water.

The fluid compartments are kept apart by minute but effective semipermeable membranes. For example, the membrane of the red blood cell is of the order of one millionth centimeter in thickness,[4] yet it is 100 million times less permeable to glycerol than an equivalent thickness of water.[5] The osmotic pressure of the plasma proteins, about 20 mm. of mercury, also is important in keeping the vascular compartment intact (Starling's hypothesis). At the arterial ends of the capillaries the pressure forces fluid out of the capillaries diminishing the size of the vascular compartment. Toward the venous ends of the capillaries, as the hydrostatic pressure falls, the osmotic pressure of the serum proteins draws fluid back into the vascular compartment. Normally the level of serum proteins is about 7 gm. per 100 ml. of blood (16 mEq. per liter); but when this falls to 4.5 gm. per 100 ml. of blood (10 mEq. per liter) or less, the osmotic pressure is no longer sufficient to draw fluid back into the capillaries, and edema may result. The ratio of the concentrations of the main serum proteins, albumin to globulin, is usually stated as 2:1. This relationship is frequently altered. For example, in certain liver diseases serum albumin may be diminished; whereas in obstructive jaundice, or multiple myeloma, globulin may be elevated.

The daily water intake varies greatly. For the adult it is roughly 50 ml. per kg. of body weight or 2,500 ml. per day, for the child 75 ml. per kg. of body weight or 1,000 ml. per day, and for the infant 125 ml. per kg. of body weight or 700 ml. per day.

Water loss occurs through the kidney, lungs and skin, and stool (Table 1).

TABLE 1—*Average 24-Hour Water Loss*

	Urine (ml.)	Lungs and Skin (insensible water loss) (ml.)	Stool (ml.)
Infant (2–10 kg.)	200– 500	75– 300	25– 40
Child (10–40 kg.)	500– 800	500– 800	40–100
Adolescent or Adult (60 kg.)	800–1,000	600–1,000	100

The pH of the blood is about 7.4 ± 0.05. It should be pointed out that for each individual, the pH within this range remains rela-

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tively constant. Abrupt changes of 0.1 pH unit or more may be very serious. The blood is maintained at its pH in spite of changes in acid or base concentrations by buffers. These buffers are systems of weakly ionized salts and acids which permit relatively large changes in their concentrations with relatively small changes in pH. The Henderson-Hasselbalch equation expresses the pH of a buffered solution in terms of the ratio of the logarithms of the salt to acid concentrations. From this expression, as concentrations of buffer salts or acids change, the pH changes may be calculated. The three main buffer systems are the bicarbonate, the phosphate, and the proteins (serum proteins and hemoglobin). The bicarbonate buffer is probably the most important one, although the phosphate buffer is also a major one in the kidney. Hemoglobin plays a dominant role in transporting bicarbonate from the tissues to the lungs. Reduced hemoglobin releases sodium in the tissues to neutralize and combine with bicarbonate. In the lungs, oxyhemoglobin, being a relatively stronger acid than reduced hemoglobin, combines with bicarbonate. Through the action of carbonic anhydrase, carbon dioxide is then liberated and exhaled.

The concentrations of solutes in body water are best expressed in milliequivalents per liter, which are thousandths of an equivalent weight per liter. For water balance discussions, one may define an equivalent weight as the weight in grams of an ion or compound which contains or will react with or equals in valence one gram atom of replaceable hydrogen ion (H^+) or 1 gram molecule of hydroxyl ion (OH^-). An equivalent weight of a compound dissolved in water and diluted to 1 liter will make a 1 normal solution. If the molecular weight equals the equivalent weight, this would also be a 1 molar solution. A 1 normal solution and a 1 molar solution need not contain the same number of equivalents, however. For example, 1 gram mole of phosphoric acid, H_3PO_4, contains 3 equivalent weights, because it has 3 replaceable hydrogen ions. One gram mole of H_3PO_4 dissolved and diluted to 1 liter with water would make a 1 molar solution, and a 3 normal solution, i.e., 1 normality for each replaceable hydrogen ion. This molar solution of phosphoric acid when completely ionized would also be a 4 osmolar solution. This latter term is used in speaking of osmotic pressure in the fluid compartments of the body; the phosphate ion and the 3 hydrogen ions are each equal to one osmole.

Clinically, plasma electrolytes are the most frequently measured ions. Plasma electrolytes having a positive (+) charge are called bases, and are cations since they migrate toward the negative electrode or cathode in an electric field. Plasma electrolytes having a negative (—) charge are called acids, and are anions since they travel toward the positive electrode or anode in an electric field.

Commonly measured anions of the plasma are:

	mEq./liter (adult values)
Chloride	100–110
Bicarbonate	25–30

Commonly measured cations of the plasma are:

	mEq./liter (adult values)
Sodium	135–147
Potassium	3.5–5.5

Plasma in infants differs from plasma in adults in that infant plasma contains more chloride, about 110 mEq./liter, and less bicarbonate, about 20 mEq./liter. Infant plasma contains more phosphates (2.3 to 3.8 mEq./liter compared to 1.8 to 2.3 mEq./liter for the adult), and less plasma protein (about 5 gm. per 100 ml. plasma as compared to about 7 gm. per 100 ml. for the adult).

Particular care must be used in calculating amounts of parenteral fluids to be given to children, since a child is less able to compensate for an electrolyte imbalance than an adult. This is because of a child's relatively greater metabolic rate, and his relatively larger interstitial fluid compartment. Forty per cent of a child's body weight is interstitial fluid as opposed to 15% in the adult. In addition, a child has decreased renal tubular absorption, a lower order of glomerular efficiency, and exchanges about 50% of his extracellular water daily as compared to only about 15% for an adult.

Sodium is the most important ion in controlling extracellular fluid volume and isotonicity. The average needs of an adult are supplied by about 77 mEq. of sodium per day (4.5 gm. sodium chloride). An infant requires 2 to 3 mEq. sodium per kg. of body weight per day. The concentration of sodium in the plasma is controlled by action of the anti-diuretic hormone of the pituitary gland on renal tubular absorption of water, and by action of the adrenal cortical hormones,

principally aldosterone, on tubular re-absorption of sodium. Potassium is the principal intracellular ion, its concentration inside the cell being about 25 times that outside the cell. There is no good renal mechanism known for re-absorption of potassium, so that once potassium is lost from the cell, it is rapidly excreted in the urine. About 40 mEq. potassium (3 gm. potassium chloride) is the daily requirement for an adult. Infant requirements are not precisely known but are thought to be about 0.5 mEq. per kg. of body weight per day.

Plasma electrolyte values may or may not accurately reflect the concentrations of these ions in the interstitial and intracellular compartments. As a result, calculations of deficits of sodium and potassium on the basis of their concentrations in plasma are only rough approximations.

Since there is relatively little intracellular sodium, a deficit of sodium may be calculated on the basis of its concentration in extracellular water which is 20 per cent of the body weight. Potassium deficits, being principally intracellular, may be calculated on the basis of intracellular water or 50 per cent of the body weight. It is convenient to remember in making calculations that 1 gm. of sodium chloride is equal to approximately 17 mEq. sodium chloride

$$\left(\frac{1 \text{ gm. NaCl}}{.05845 \text{ gm. NaCl/mEq.}} = 17.1 \text{ mEq. NaCl}\right),$$

and 1 gm. of potassium chloride equals approximately 13 mEq.

$$\left(\frac{1 \text{ gm. KCl}}{.07455 \text{ gm. KCl/mEq.}} = 13.4 \text{ mEq. KCl}\right).$$

Two brief illustrative examples are as follows:

Example 1

Gastric resection, subtotal in a 40-year-old man weighing 70 kg. (155 pounds), for duodenal ulcer.

Day of Surgery

INTRAVENOUS FLUIDS:

1,000 ml. whole blood, to replace blood estimated to have been lost at surgery. This is not counted in calculating other fluids to be replaced.

1,000 ml. 5% glucose in distilled water to replace fluid lost at surgery (2 hours), determined by weighing the patient before and after surgery. On a very warm day 2,000 ml. or more may be necessary.
1,000 ml. 5% glucose for 24-hour insensible water loss.
1,000 ml. 5% glucose for urine loss.
250 ml. 5% glucose to replace gastric drainage.
3,250 ml. 5% glucose in water, total for 24 hours.

Sodium chloride is not given for the first 24 hours unless there is a deficit because of the sodium retention from increased aldosterone secreted during stress. This further intensifies water retention already occurring from increased secretion of the antidiuretic hormone. Even without additional salt, the net effect of aldosterone and the antidiuretic hormone may be to reduce urine secretion to 500 ml. on the day of surgery. Potassium, likewise, is not given as a rule during that period because aldosterone causes most of the administered potassium to be excreted by the kidney. In addition, plasma potassium may rise from a shift of intracellular potassium to extracellular spaces as a result of tissue damage.

Since toxic concentrations of potassium may occur following its administration in the absence of good renal function, as a general rule dehydration should be corrected and urine excretion should be adequate (30 to 40 ml. per hour) before giving potassium. Toxicity is manifested by a characteristic elevation or "tenting" of the T-waves of the electrocardiograph and irregularities of cardiac rate and rhythm. This may lead to circulatory collapse and cardiac arrest at blood levels of 10 to 11 mEq. per liter.

First Postoperative Day

Measured fluid loss: 500 ml. gastric drainage, 950 ml. urine.

Gastric drainage may be replaced volume for volume with saline unless drainage is very large; i.e., 1 liter or more, in which case half of the volume is replaced with saline and half with 5% glucose. This is because gastric drainage, although higher in chloride than sodium, still contains roughly only one half the ionic concentration of saline. The potassium content varies, but a value of 13 mEq. per liter gastric juice may be taken as an approximation.

INTRAVENOUS FLUIDS:

1,000 ml. 5% glucose in saline. Five hundred milliliters, or 77 mEq. sodium chloride, is for replacement of loss from gastric drainage, and the remainder of the salt is for normal body needs.

1,500 ml. 5% glucose in distilled water supplies the remaining fluid for the 2,000 ml. daily requirement plus gastric loss.

One hundred and twenty-five grams of glucose in 2.5 liters supplies 500 calories. Using glucose for energy spares protein for use in reparative processes. It also permits more efficient utilization of fat and thus helps prevent acidosis by decreasing loss of sodium with ketone bodies.

POTASSIUM:

If urinary output is adequate, as it is here, this may be given since the patient will be fed intravenously for some time. About 46 mEq. should be adequate, 40 mEq. for minimal daily requirements, and 6 mEq. for replacement of gastric losses. Ten milliliters of 10% potassium chloride, 13 mEq., may be added to the first liter of fluid, and if tolerated, 33 mEq., 2.5 gm., may be added to the next liter.

VITAMINS:

Water soluble vitamins are also given because of prospects of prolonged intravenous feeding. These are added to 1 liter of intravenous fluids. Several good mixtures are available.

The patient continues on this regimen for 5 to 6 days until he has bowel sounds and passes flatus. At this time, if he tolerates water orally, daily intravenous fluids may be decreased to 1,000 ml. of 5% glucose in 0.45% saline. After this further intravenous fluids may not be needed.

Example 2

A 30-year-old woman, unable to take fluids, has severe diarrhea. In a 12-hour period her weight drops from 60 to 55 kg. Her serum sodium is 120, potassium 2.5, chloride 92 and bicarbonate 12. The arterial pH is 7.3 and the hematocrit 51. The patient is dehydrated, depleted of electrolytes and acidotic. She will need 5 liters of fluid to replace the weight loss from the diarrhea and in addition fluid for continuing losses from the bowel plus 2 liters for normal daily requirements.

The sodium deficit is approximately 264 mEq. It is calculated as follows:

142 mEq.Na/L. normally
—120 mEq.Na/L. observed

22 mEq.Na/L. deficit × 12 liters ECF (20% body weight) = 264 mEq.Na

This is equivalent to approximately 15 gm. sodium chloride

$$\left(\frac{264 \text{ mEq. sodium}}{17 \text{ mEq. sodium/gm. sodium chloride}} = 15 \text{ gm. sodium chloride}\right)$$

The chloride deficit is 156 mEq.

105 mEq.Cl/L. normally
— 92 mEq.Cl/L. observed

13 mEq.Cl/L. deficit × 12 liters ECF = 156 mEq.Cl

and is equivalent to approximately 9 gm. of sodium chloride

$$\left(\frac{156 \text{ mEq. chloride}}{17 \text{ mEq. chloride/gm. sodium chloride}} = 9 \text{ gm. sodium chloride}\right)$$

The potassium deficit is 60 mEq.

4.5 mEq.K/L. normally
—2.5 mEq.K/L. observed

2.0 mEq.K/L. × 30 liters ICF (50% body weight) = 60 mEq.K

This is equivalent to about 4.5 gm. of potassium chloride

$$\left(\frac{60 \text{ mEq. potassium}}{13 \text{ mEq. potassium/gm. potassium chloride}} = 4.6 \text{ gm. potassium chloride}\right)$$

Since plasma contains more sodium (142 mEq./L.) than chloride (105 mEq./L.), sodium chloride is given in replacing sodium only to the extent that the chloride deficit is corrected. More sodium chloride would result in a relative excess of chloride and a metabolic acidosis. Additional sodium is given as sixth molar sodium lactate. This latter has the effect of giving sodium alone since lactate is metabolized. The sodium and chloride deficits may be corrected as follows:

	mEq.Na	mEq.Cl
1000 ml. isotonic saline	154	154
700 ml. M/6 sodium lactate (0.7 × 167 mEq.Na/L.)	117	
	271 mEq.Na	154 mEq.Cl

Most of the 5 kg. loss was from the extracellular fluid and for this 3 parts of isotonic saline and 1 part of M/6 lactate are administered.

Continuing diarrheal losses are estimated from current measurements as likely to be about 2,000 ml. for the next 24 hours and may be replaced with saline and M/6 lactate in a 2:1 ratio, which gives roughly the ionic concentration of intestinal fluid. The total 24-hour need is then about 9,000 ml., 2,000 for metabolic needs, 5,000 for extracel-

lular fluid replacement and 2,000 for continuing diarrheal losses, and is summarized:

	ml. saline	ml. M/6 lactate
Sodium and chloride deficit	1,000	700
Extracellular fluid replacement	3,750	1,250
Intestinal (diarrheal) replacement	1,333	666
Total	6,083	2,616

If 6 liters of saline and 2.5 liters of M/6 lactate were given, the remaining 500 ml. to total 9 liters might be given as 5% glucose in water.

After the patient has received 3,000 ml. fluid and has an adequate urine excretion (30–40 ml./hr.) 13 mEq. potassium (1 gm. potassium chloride) may be added to the next liter.

If this is well tolerated 26 mEq. (2 gm.) potassium chloride are added to each of the next 3 liters. Seven grams of potassium chloride (91 mEq.) supplies the 40 mEq. daily requirement and much of the 60 mEq. deficit, but potassium deficits as a rule cannot be replaced in 24 hours and may require several days for correction.

It must be kept in mind, however, that all of the above calculations are only estimates and may be altered depending on the response and condition of the patient.

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ANNOUNCEMENT OF NATIONAL HEMOGLOBIN SURVEY

To Be Conducted by College of American Pathologists—December 1961

In order to stimulate interest in the accuracy of hemoglobin measurements, the College of American Pathologists' Standards Committee announces a National Hemoglobin Survey available to all physicians and hospitals.

Hemoglobin measurement is one of the fundamental screening measurements in the practice of medicine. The decision for the need for blood transfusions rests upon this test. It has been shown that inaccurately calibrated hemoglobin photometers may lead to unnecessary transfusions.* Accurate diagnosis and treatment of hematologic disorders also depend upon reliable hemoglobin measurements.

Hemoglobin measurements must be consistent from year to year so that patients have the benefit of continued observations. Therefore, photoelectric photometers used for hemoglobin measurements should be frequently calibrated with a stable hemoglobin standard.**

Participants will receive a set of survey samples as well as a critique on the accuracy and precision of hemoglobin measurements plus suggestions for increasing the reproducibility under practical conditions. Questions concerning calibration of photometers for hemoglobin measurement may also be directed to the committee.

Those who wish to participate in this hemoglobin survey may do so by sending $10.00 to the Standards Committee, College of American Pathologists, Prudential Plaza, Chicago 1, Illinois.

* PAS Report No. 36, Hemoglobin Commission on Professional and Hospital Activities Committee, Ann Arbor, Michigan.

** The Standards Committee recommends the use of the National Research Council Cyanmethemoglobin Standard Certified by the Standards Laboratory of the College of American Pathologists for its stability and its ease of use. The standard is available from Ortho Pharmaceutical, Michael Reese, and Hycel Company.

Division of Medical Sciences—National Research Council. SCIENCE, *127:* 1376, 1958.

A Review of Available Anti-Tumor Chemicals for Clinical Human Use

By JOHN D. HURLEY, M. D., LARRY C. CAREY, M. D., and LOREN J. YOUNT, M. D.

Milwaukee, Wisconsin

CHEMOTHERAPY at present is useful in the treatment of selected advanced cancers. Even though the duration of benefit for most patients is relatively short and the number who benefit is small, the results in some patients are encouraging enough to warrant more intensive study of this modality of treatment.

A great number of agents are available, 15 to 20 of which are useful in the treatment of human cancer. Difficulties in the management of patients with advanced cancer are multiple. Because of the many problems arising from the treatment itself, we must have an understanding of the chemistry, biochemistry and physiology of the drugs before they are used. Toxicity of many types is frequent and can be severe, and death does occur if dosage schedules are not carefully titrated to the individual patient. Because of great variation in patient response to these chemicals, no one standard formula is satisfactory for the treatment of all patients and each patient should be evaluated individually for therapy with the particular agent or agents under consideration.

The agents fall usefully into four large groups:

1. Alkylating agents such as nitrogen mustard (HN_2), triethylene melamine (TEM), triethylene thiophosphoramide (TSPA), chlorambucil, cytoxan, phenylalanine mustard (PAM) and many newer experimental agents.

2. Antimetabolic agents such as aminopterin, amethopterin, or methotrexate (MTX), 5-fluorouracil (5–FU), 6-mercaptopurine (6-MP), and others.

3. Antibiotic agents such as actinomycin D and mitomycin C, and a large group of new antibiotic agents now being developed.

4. Miscellaneous agents such as urethane, aminoiminomethane sulfinic acid (AIMSA) and other interesting newer synthetic compounds, many of which have toxicity unrelated to bone marrow depression. Toxicity has been seen, however, with all of the agents tested so far.

Drugs Available

The alkylating agents have a limited usefulness for certain tumor areas. The best results have been obtained in carcinomas of the ovary, lung, gallbladder and biliary tree and areas of the head, neck, pelvis and extremities that can be reached by perfusion techniques. The response of melanoma to phenylalanine mustard has been particularly favorable.

The antimetabolic agents have been useful in carcinomas of the breast, colon, stomach, pancreas and areas of head and neck and pelvis accessible to infusion.

The antibiotics such as actinomycin D have been most useful for certain sarcomas and tumors such as Wilms' tumor of children. We have had extensive experience with the use of antibiotics in combination with one of the alkylating agents, and the results have been most gratifying, particularly in carcinoma of the lung and stomach.

The miscellaneous agents have no clear-cut role as yet. Most of these agents are new and relatively untested, but are exciting. Some, such as AIMSA, are nephrotoxic, others have principally hepatic or other organ toxicity rather than bone marrow toxicity. These agents also appear to be useful in combination therapy. Marrow toxic agents can be combined with nephro- or hepato-toxic

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drugs with no apparent increase in drug morbidity.

It must be emphasized, however, that all of these drugs accomplish only palliation and usually short-term palliation. Prolonged and gratifying palliation, for twelve or more months, is seen in only five to ten per cent of all patients treated with any of the agents tested thus far.

Selection of Patients

In a review of over 1,000 patients treated at the Milwaukee County Hospital, certain useful criteria of selection have evolved. They are based on the following factors: (1) effect of the drug, (2) duration of disease, (3) type of prior therapy, (4) site of metastatic spread, (5) tumor cell type, and (6) age and status of the patient.

The relative effectiveness of the drugs in various cancers has been discussed above.

The total duration of the disease is important and reflects the ability of the patient to live with his disease. Host resistance certainly plays some as yet unknown role in enhancing the benefits from chemotherapy.

Prior therapy, in some areas, is of importance. In breast and colon carcinoma, better results are seen when the primary tumor is removed and in pancreatic carcinoma when the obstructing lesion is bypassed and jaundice relieved. This will probably also be true in carcinoma of the esophagus and in other areas where surgical procedures will permit the patient to maintain a better nutritional status. Removal of the bulk of tumor tissue will also decrease the total volume of tumor that has to be treated and altered by the anti-tumor drug. Considerably better subsequent palliation is obtained with anti-tumor agents in patients with cancer of the breast who previously had responded to endocrine therapy than in those who did not respond to such therapy or who did not receive it.

The site of metastatic spread is important in selecting patients for a systemic anti-tumor agent as well as in predicting a response to these agents. For most of the tumor agents studied, local or regionally recurrent or residual disease is more responsive than widespread metastases. Certain areas of metastatic spread are poorly responsive to systemic chemotherapy and patients with these may often be spared the toxicity of such therapy if their general status is poor and the outlook grave. Cerebral and extensive hepatic spread is uncommonly responsive to any form of cancer chemotherapy, although occasionally useful palliation is seen even with extensive cerebral or hepatic involvement.

In general, the tumor cell type is not of major help in predicting response to carcinolytic drugs. Our experience, however, for pulmonary and some other tumor areas would indicate that the more differentiated tumors are more responsive in general than the more anaplastic or undifferentiated tumors. This is of some importance in selecting patients who should be given such therapy.

The age and general physical status of the patient are of relative importance. Patients over 75 and the more debilitated patients, in general, tolerate chemotherapy much less well than younger, more vigorous and better nourished patients. The drug morbidity and mortality is highest among older and debilitated patients and therapy should be cautiously given, if used at all.

Chemotherapy as Adjunct

Nationwide studies are under way concerning the role of these agents in treatment of patients with operable and seemingly curable disease as an adjunct to surgical procedures. Destruction of the free floating but viable tumor cells that are known to circulate in the blood stream of patients, even with apparently curable cancers, would seem to be ideal treatment. The amount of chemical needed to accomplish this should be much less than that required for a larger, better established metastatic deposit. Complete destruction of all viable tumor cells is certainly theoretically possible. The results to date, unfortunately, have not borne out this premise, except with cancer of the breast and with TSPA, which has been shown to be beneficial. The results with tumor of the lungs, stomach and colon, have been disappointing. However, newer agents and perhaps better agents are constantly being developed and must be evaluated by the same careful nationwide cooperative study. It is hoped that safe and effective agents will be developed which can be utilized as adjuncts to the surgical attack on potentially curable cancers of many more areas.

Summary

A large number of somewhat useful anti-tumor agents are available. They have a limited, but important role at present, in the

palliation of advanced cancer. These drugs can be classified into four major groups and each group of agents seems most useful for a somewhat different tumor spectrum. Careful patient selection is important to obtain maximal palliation with the least risk of serious drug toxicity and drug death. Certain useful criteria of selection have been presented to assist prediction of patient response to a particular anti-tumor agent. Adjuvant therapy with anti-cancer drugs has proven useful thus far, only for breast cancer. Different approaches and newer drugs may offer similar benefits in other tumor areas.

OTOLOGICAL–AUDIOLOGICAL DIAGNOSTIC CLINIC NOW IN OPERATION AT UNIVERSITY OF WISCONSIN

The Speech and Hearing Rehabilitation Center, in cooperation with the Department of Otolaryngology, University Hospitals, Madison, initiated a new diagnostic clinical service in September. The title of the new service, which is held in the Speech and Hearing Rehabilitation Center on the fourth Monday of each month during the academic year and regular summer session, is the Otological–Audiological Diagnostic Clinic. The first clinic was held September 5.

The purpose of this clinic is to offer the people of Madison and throughout the state of Wisconsin a service which fully investigates the medical and audiological aspects of their hearing loss and arrive at decisions and recommendations as to medical, surgical, educational, and/or rehabilitative measures. No treatment of any type is given in this clinic. If medical or surgical care is indicated, this can be obtained at the University Hospitals in the regular manner, or from the patients' own otologist. If nonmedical rehabilitation is indicated, i.e., hearing aid evaluation or speech or hearing therapy, it can be obtained at the Speech and Hearing Rehabilitation Center or in the patients' own localities if available.

The type of patients seen in this clinic are those with unusual or difficult hearing problems either from a medical or educational rehabilitation standpoint in which the referring agency or physician is desirous of a more complete and detailed diagnostic examination. Patients being considered for reconstructive middle ear surgery may be seen in this clinic on a pre- and postoperative basis, providing the surgeon with more complete audiological information.

The ages of patients seen in this clinic range from about four years through adulthood. Children younger than four years require a different type of evaluation and are seen at other times.

In addition to the actual service to the patient, the clinic provides training for resident physicians in the Department of Otolaryngology and graduate students in speech pathology and audiology. It is also anticipated that this new service will be the impetus for additional research in the fields of otology and audiology. Furthermore, it coordinates and brings together the otologic and audiologic services available at the University of Wisconsin.

The hearing evaluations are under the direction of John L. Peterson, Ph.D., supervisor of the Speech and Hearing Rehabilitation Center, and Claude S. Hayes, Ph.D., associate director of the Speech and Hearing Clinics, both in the Department of Speech, and they are assisted by graduate students in audiology. Any necessary speech evaluations are under the direction of Arnold E. Aronson, Ph.D., of the Department of Speech, assisted by graduate students in speech pathology. The otological examinations are under the direction of Maxine Bennett, M.D., chairman of the Division of Otolaryngology, University Hospitals, assisted by resident physicians in otolaryngology.

The audiologic testing is done in the morning beginning at 9 a.m. and the otologic examination is conducted early in the afternoon. Staffing then takes place and recommendations are made to the patient, with the clinic ending at 3 or 4 p.m. The service can accommodate four patients during each clinic day. This allows sufficient time to administer a thorough and complete battery of tests. Reports of the examination are sent to the referring agency or physician, and the patient or his parents.

one of a series

ROENTGEN RIDDLE . . .

HISTORY: A 55-year-old white male who has been hypertensive for years entered with cough, dyspnea, and pedal edema.

PHYSICAL EXAMINATION: Blood pressure, 210/100; pulse, 120; respiration, 20 per minute; temperature, 98.6 F. Distended neck veins, bilateral basilar rales and dullness in the chest on the left side were the principal findings.

Prepared by Alphonse Richter, M.D., resident in radiology at Milwaukee County Hospital, under direction of John R. Amberg, M.D., radiologist, Department of Radiology at Milwaukee County Hospital.

CLINICAL IMPRESSION: Congestive heart failure with pleural effusion.

X-RAY: The posteroanterior chest roentgenogram revealed cardiomegaly, obliteration of both costophrenic angles by homogenous arcuate densities and prominent pulmonary vasculature. In addition, the fourth right anterior interspace revealed a sharply circumscribed density. No evidence of cavitation within the density was noted.

SEE DISCUSSION ON PAGE 621

Sponsored by Section on Pathology
State Medical Society of Wisconsin

CLINICOPATHOLOGIC CONFERENCE

Guest Editor: PHILIP G. PIPER, M. D.
Modison, Wisconsin

CASE PRESENTATION*

A 22 year old white man was admitted to the hospital with the complaint of black stools. He stated that he had been perfectly well and had gone to work the day of admission. At 9 a.m. he defecated and observed a tarry black stool. At 10 a.m. he felt nauseated and light-headed. At 11 a.m. he had an emesis of a large quantity of bright red blood and was admitted at 1 p.m. A provisional diagnosis of upper gastrointestinal bleeding of undetermined origin was made. The patient was observed, treated conservatively and responded well with cessation of the hemorrhage.

An upper gastrointestinal x-ray series was performed and was interpreted as showing an active duodenal ulcer. One observer during admission recorded his funduscopic examination as revealing hazy discs. The patient was dismissed improved two days later and was placed on an ulcer regimen.

The patient was re-admitted to the hospital two and one-half months later. He stated that he was asymptomatic until the day before admission at which time he had a sudden onset of severe bilateral frontal and temporal headaches. On the morning of the day of admission he had several large emeses which he stated contained no fresh or old blood. Shortly afterwards he had a generalized seizure which was interpreted as a grand mal convulsion. The patient and his parents denied a history of trauma, paralysis, paresis, vertigo or personality change. The father stated that the son had been an average student in school and had no known sociological problems. A review of systems revealed that he had had a severe otitis media at the age of two with resultant complete deafness in the left ear. He had had on occasion a minimal serious drainage from this ear since that time. He was rejected from military service presumably because of difficulty with his ear. There was no family history of epilepsy, convulsive seizures or mental illness.

Physical examination revealed an apprehensive white man who had a minimal paraphasia. The pulse was 88, respirations 18, blood pressure 150/74 (left arm, supine). The veins of the neck were not distended. The thyroid gland was not palpable and there was no demonstrable lymphadenopathy. Examination of the chest revealed no significant abnormalities. There was no demonstrable cardiomegaly, auscultation was unremarkable, and a normal sinus rhythm was present. The abdomen, external genitalia, rectum and musculoskeletal system were unremarkable. The peripheral pulsations were intact.

On neurological examination the pupils were round, regular and equal and they reacted to light both directly and consensually. On funduscopic examination there were 2 to 3 diopters of papilledema bilaterally and drusen bodies were present on each optic disc. The visual fields appeared unremarkable and the extra-ocular muscles were intact. One observer felt there was a minimal weakness of the right facial muscles and the right arm and leg. The patient was right-handed. The deep tendon reflexes in the right arm and leg were slightly increased over the left; and there was a bilateral positive Babinski reflex, 3+ on the right and 1+ on the left. The abdominal and cremasteric reflexes were symmetrical and present. No impairment of sensory perception was demonstrable. Shortly after admission the patient's sensorium became quite clouded.

Initial laboratory studies revealed the urine to have a specific gravity of 1.017, 1+ albumin, glucose negative, 1+ acetone, and the microscopic examination revealed 1 to 2 white blood cells per high-power field. Examination of the blood revealed a hematocrit reading of 52%, hemoglobin of 16.4 gm. per 100 ml., and a white blood cell count of 17,000 with 2% metamyelocytes, 5% bands, 87% segmented neutrophils, 5% lymphocytes, and 1% monocytes. The spinal fluid showed 22 white blood cells, including 3 segmented neutrophils and 19 lymphocytes; 5,250 red blood cells; total protein 50 mg. per 100 ml.; and sugar 87 mg. per 100 ml. The test for syphilis was negative.

Skull x-ray films revealed the pineal body to be uncalcified. There was a questionable separation of the coronal and lamboidal sutures. The sella tursica was a little large and showed a double floor. These findings could be compatible with increased intracranial pressure. X-ray films of the cervical spine were unremarkable. A ventriculogram revealed the lateral ventricles to be enlarged in their entirety. No air was seen in the third or fourth ventricles. The question of herniation of the cerebellar tonsils into the foramen magnum was postulated by the roentgenologist.

The day after the second admission the patient was taken to surgery for craniotomy. His postoperative course was stormy, and he died the next day.

*From Madison General Hospital.

Discussion

Dr. Henry Suckle: The review of the first hospital admission indicates that the patient most certainly had a definite duodenal ulcer. This was not only corroborated clinically with the defecation of a tarry black stool but also the emesis containing bright red blood. This was confirmed by the demonstration of an active duodenal ulcer on x-ray examination.

It is interesting to speculate in retrospect in this case the relationship of the duodenal ulcer to the intracranial lesion found later. Although most gastrointestinal tract ulcerations occur with pituitary or hypothalamic lesions, they have been found in lesions of the fourth ventricle. The exact relationship between the two is not known. However, most gastrointestinal lesions develop terminally when associated with intracranial lesions, so that the relationship in this case between the first admission and the findings of an intracranial lesion on the second admission is in great doubt.

The second admission, slightly more than two months later, was ushered in by a severe headache and emesis. Since no blood was found, there was no suggestion of a recurrence or reactivation of the duodenal ulcer; and I presume that there was no suggestion of blood in the stool or this would have been recorded in the clinical summary. However, on this occasion there was a suggestion of definite intracranial abnormality or neurological findings; namely, bilateral papilledema, minimal aphasia, minimal weakness of the right facial muscles and the muscles of the right upper and lower extremities, increased reflex of the right arm and leg, and bilateral positive Babinski signs. The x-ray films also showed signs of increased intracranial pressure in that it was noted that there was a questionable separation of coronal and lambdoidal sutures. The cerebrospinal fluid findings were not necessarily of particular significance. The finding of 5,250 red blood cells was approximately 1/1000 of the amount of red blood cells found in this patient's blood as he had a hematocrit reading of 52% and a hemoglobin of 16.4 gm. per 100 ml. His white blood cell count was likewise elevated to 17,000 on admission and two days thereafter the spinal fluid white blood cell count, being taken at 1/1000 of the blood count, could easily account for the white cells seen in the spinal fluid so that the cellular content of the spinal fluid was not of as great significance. It is noteworthy that no mention was made of bacteria, which would tend to rule out an infectious intracranial process.

Differential Diagnoses

Therefore, coming to the time of the air study the following diagnostic possibilities existed:

(1) A left-sided intracranial lesion accounting for the minimal aphasia and the right-sided neurological signs. This could be due to a tumor or even an abscess as the patient had had a long history of left middle ear disease.

(2) A midline lesion, either in the third ventricle midbrain or the fourth ventricle accounting for the increased intracranial pressure as evidenced by the bilateral papilledema and the bilateral positive Babinski signs.

(3) An arachnoiditis secondary to the left middle ear disease.

The air study demonstrated that there were bilateral enlargements of the lateral ventricles without any filling of the third and fourth ventricles and with a question of herniation of the cerebellar tonsils into the foramen magnum, ruled out the left cerebral hemispheric lesion and ruled out the first differential diagnostic possibility. It likewise eliminated an arachnoiditis because the third and fourth ventricles are usually seen in arachnoiditis since this tends to block the outlet of the lower end of the fourth ventricle rather than the portions of the ventricular system.

Therefore, at the time of surgery the most likely diagnosis was that of a midline lesion either in the posterior portion of the third ventricle, the midbrain to include the aqueduct and the fourth ventricle or the posterior fossa.

I presume that the surgery consisted of a suboccipital craniotomy. At this time the fourth ventricle was undoubtedly explored; and if a tumor was found, then the diagnosis was made. If no tumor was found, the cerebellar hemispheres must certainly have been explored by tapping to rule out either a cyst, an abscess, or even a tumor. Again, if lesions were found in the cerebellar hemispheres, they would complete the diagnosis. However, lack of finding of any abnormalities in the cerebellar hemispheres would lead the operator to insert a catheter through the fourth ventricle, the aqueduct and into the third ventricle. If this could not be accomplished, then the diagnosis of the midbrain aqueductal or posterior third ventricle lesion could be made and a Torkildsen operation or ventriculocisternal anastomosis would then be performed to circumvent the obstruction. The death within a day following the craniotomy could be due to several factors: hemorrhage or swelling within an inoperable or undisclosed lesion or a postoperative hemorrhage. It is unlikely that the patient had a postoperative hemorrhage because this would have been diagnosed by the re-exploration of the operative wound. Likewise, hemorrhage within a lesion postoperatively is not as common as postoperative edema; and therefore, I believe the patient died of swelling in an inoperable lesion in the midbrain structures.

Dr. Robert C. Schmitz: The lateral view of the x-ray films revealed a dilatation of the lateral ventricles. The third ventricle and fourth ventricle were not seen. One of the films showed a compression of the tonsils into the foramen magnum.

Fig. 1—A cross section through the brain showing the dilated lateral ventricles, beneath which 4 cross sections through the aqueduct of Sylvius reveal the point of stenosis to be in the second section from the right. The aqueduct is surrounded by a focal hemorrhage.

Dr. L. William Kleppe: Were there any other skull x-ray films?

Doctor Schmitz: No, we had cervical spine and chest x-ray films.

Comment

Dr. Francis Hummer: This man came into the hospital with a complaint of a grand mal type of convulsion which was preceded by moderately severe headaches and emesis. With the history of a chronic otitis media which he had had since the age of two and evidence of purulent drainage in the canal at the time of admission, the primary impression was one of brain abscess which to the internist seemed the most logical. It was only after neurosurgical consultation was obtained that this possibility was ruled out. There was one other factor which deserves comment but cannot be completely clarified. On the preliminary admission two months prior to the second admission, the intern who examined the patient questioned whether he had papilledema. Unfortunately, the staff member failed to follow up this particular finding, feeling that there was massive gastrointestinal hemorrhage due to peptic ulcer. It would have been significant to have that information two months before the acute onset of symptoms. From the later findings, it would have made no appreciable difference in the outcome of the patient but would have made it easier for the neurosurgeon to establish the diagnosis.

Dr. George Berglund: On the basis of the rationale as outlined by Doctor Suckle in the discussion, a posterior fossa exploration was undertaken. The cerebellar hemispheres were symmetrical. They were explored by needle biopsy, considering the possibility of an abscess on the side of the otitis.

Prior to this the cerebellar pontine angles had been explored and no lesion was found. Grossly there were no findings suggestive of a chronic arachnoiditis. The cerebellar tonsils were not herniated beneath the first cervical vertebral arch. The fourth ventricle was examined. It appeared to be normal and there was no enlargement or distortion of the floor of the fourth ventricle. No fluid was seen to drip from the posterior end of the aqueduct, and it was felt that we were dealing with an obstruction, either in the posterior third part of the ventricle or in the aqueduct, so a Torkildsen ventriculocisternostomy via a left occipital trepination was done. Postoperatively the patient had a stormy course and there was some suggestion that there was weakness of the right side. This was difficult to evaluate because of his coma. The trepination area was explored through the wound, and there did not appear to be a hematoma beneath this site. The cerebral cortex was up against the dura in this area.

Autopsy Findings

Dr. Philip G. Piper: The significant lesions found at autopsy were a 0.5 cm. healing duodenal ulcer

Fig. 2—An anterior–posterior x-ray film showing the dilated lateral ventricles. The third and fourth ventricles are not visualized.

Fig. 3—A lateral skull x-ray film showing the dilatation of the lateral ventricles. The third and fourth ventricles are not visualized.

3 cm. from the pylorus with no recent evidence of bleeding and a massive organized extradural hematoma involving the whole left hemisphere which caused a marked compression of the left cerebral cortex with an associated deviation of the cortical wall into the dilated lateral ventricle on the left side. A marked internal hydrocephalus was found involving the ventricular system (Fig. 1). The cause of this internal hydrocephalus was a congenital stenosis found within the mid portion of the cerebral aqueduct. There were no neoplastic or inflammatory lesions in this area to account for the reduction of the luminal diameter of the aqueduct, either on gross or microscopic examination.

One important finding in the case was that on the first admission of this patient to the hospital, an intern interpreted the funduscopic examination as presenting hazy discs indicating the possibility of a hydrocephalus in the absence of central nervous system symptomatology. On the second admission the roentgenographic examination of the skull films presented a questionable separation of the coronal and lambdoidal sutures and revealed the dilated ventricular system (Figs. 2 and 3). If the former be a true entity, then the presence of the internal hydrocephalus may have occurred before suture closure early in the developmental phase of this patient.

In the absence of any tumor mass or inflammatory lesion to account for an associated stenosis and eliminating obvious malformations, the secondary cause of glial proliferation in the area was an important consideration. This has been described by Beckett, Netzsky and Zimmerman[1] who reported 11 cases of non-neoplastic stenosis of the aqueduct. Four of their cases, however, were due to malformations and 7 were due to glial proliferations. We feel that this case represented a traditional one and manifested itself similar to those described by these authors as representing an abnormal congenital stenosis on the basis of a developmental glial proliferation.

The above investigators purposed the theme of embryology, histology and speculative pathogenesis for the development of this type of stenotic abnormality within the aqueduct of Sylvius. They described that the ventricular system develops from a primitive neural tube and with the maturation process a relative narrowing of the aqueduct takes place. The aqueduct is lined by an ependymal proliferation ranging from one cell to many cells in thickness which cause variations from a smooth to an irregular surface of the lining. Because of this proliferation, aberrant small diverticula can develop. They speculated further that the presence of aqueductules as far as relative numbers are concerned, the structure of the glial plate, and the cell variations within the glial plate itself are all suggested evidences that this abnormality is based on one of congenital histology rather than an inflammatory or neoplastic process. The relative changes, concentrations and formations of the above described structures are responsible for not only variations from the normal pattern which do occur in the nonstenotic aqueducts but also when over-emphasized in the developmental scheme of things, are responsible for a stenotic lesion. It seems that the ages of death of the patients in their series ranged from infancy to adulthood depending upon variations in the methods

of stenosis development. On occasion accessory pathways are responsible for a cerebrospinal fluid flow which acts as a compensatory mechanism preventing the rapid onset of an internal hydrocephalus sufficient to cause death. In many cases complete stenosis is found and because of the spongy consistency of the glial tissue surrounding the area where the aqueduct should be, a transfer of cerebrospinal fluid could take place.

The histology in the area of stenosis in this case most certainly fell into the classification of an astrocytic glial proliferation and was not dependent upon any abnormality in the ependymal lining. No histologic evidence of luetic involvement of the central nervous system was found at the time of microscopic examination; neither was there any histology suggestive of meningitis or encephalitis. It was our impression that this case should be classified as a congenital stenosis of the aqueduct with a pattern of manifestations similar to cases reported by other authors as well as to those described by Beckett, Netzsky and Zimmerman. We speculated without success on what mechanism manifested itself at what time to convert an already pre-existing pathologic lesion within the central nervous system from an asymptomatic to a symptomatic disease entity and that how, as compared to wide variations of normal, this lesion because of over-emphasis of one part of its progenitorial components leads the patient into a symptomatic internal hydrocephalus.

Doctor Kleppe: Would you expect more dilatation in the proximal segment of the aqueduct?

Doctor Piper: There is dilatation as compared to the normal determinations given in studies of this age group.

Doctor Berglund: Considering the marked dilatation of the ventricles, one would suspect that the process had been of rather long-standing and yet, according to the history, the patient had no headaches. The intracranial hemorrhage was on the left side, the side of the trepine exploration, and certainly wasn't present at the time of initial surgery. When we explored it postoperatively, the cortex was readily seen and there was no evidence of a hemorrhage. The exploration was necessarily limited because of the patient's poor condition.

Doctor Piper: Doctor Suckle, with the operative procedures that are described for lesions within the aqueduct and in the presence of a stenosis on a congenital basis, would such procedures offer a successful outcome as far as longevity is concerned?

Doctor Suckle: I believe they would offer a fair chance of success with longevity. Again, it depends entirely upon the effect of the original lesion on the major centers of the central nervous system and that there must have been a culmination of events that occurred in the brain stem from a functional point of view that caused the difficulties more than anything else.

Doctor Piper: Doctor Berglund, has there been determined either on the basis of physiology or neuroanatomy the degree of internal hydrocephalus which, in your opinion, would make a lesion either symptomatic or asymptomatic? Has any degree of internal hydrocephalus been established at which time one would have clinical symptoms, or is that an arbitrary thing which varies from patient to patient?

Doctor Berglund: I do not know of any studies. I am certain, as this case illustrates, that we may have marked enlargement of the ventricular system without symptoms. Another recent case brought to my attention was a 19 year old man who had been perfectly well until he had a seizure and was brought into a hospital. A lumbar puncture was done and the fluid was clear. Within 9 hours the boy died. He had marked dilatation of the ventricles caused by a congenital stenosis within the anterior portion of the aqueduct. When this area was examined at autopsy, no aqueductal lumen could be identified. Glial proliferation was responsible for the stenosis and a spongy glial plate could have accounted for the compensatory flow which kept this man symptom free for 19 years.

Doctor Hummer: Don't you believe, Doctor Berglund, that the amount of symptoms depends in a large degree on the rate of development of the pressure? If it is very slow in progression, symptoms are minimal. Whereas if it is rapid, symptoms occur and there is finally a point at which the physiology is so disturbed that symptoms are severe.

Doctor Berglund: I agree that the rate of development of an internal hydrocephalus is a factor in determining the symptoms.

Doctor Hummer: I would like to make one comment on the ulcer problem in neurosurgical disease. I agree with Doctor Suckle thoroughly that in this particular instance the ulcer was in all likelihood purely coincidental. The formations of peptic ulcers in various disease states is well known. The Curling ulcer in burns occurs almost invariably in the stomach rather than in the duodenum. It is usually acute and frequently perforates from the onset. The so-called Cushing ulcer that is associated with lesions of the central nervous system, particularly the pituitary and hypothalamic areas, was first described by Rokitansky in 1841. It usually has an acute onset and may occur in either the stomach or duodenum. This field was re-explored and brought to the attention of the medical profession in 1932 by Cushing at which time a series of cases was reported in which acute perforation of both the gastric membrane and the duodenum occurred following operations on the central nervous system. However, as Doctor Suckle said, these were terminal cases. These ulcers develop rapidly, perforate frequently and are likely to cause hemorrhage immediately. They rarely, in the reported series, went on to the healing phase as this ulcer very definitely did. Therefore, the ulcer in this instance was purely coincidental.

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Rehabilitation—A Community Challenge

By PAUL F. FLEER

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REHABILITATION offers to every community the challenge of making available to each of its disabled members those services and resources needed to achieve and maintain an optimal level of physical, social, emotional, and vocational function. It further challenges the community to co-ordinate those services and resources so that they may be applied at the time and in the place they are needed and in a manner which enhances their use.

The disabled group requiring rehabilitation services is not exclusive because of age, type of disability, financial status or potential level of achievement, but is inclusive of all disabled persons regardless of the nature of their conditions or their life situations. The young amputee with a good potential for vocational training and re-employment, and the elderly stroke victim with a potential for some level of independent self-care, are equally deserving of rehabilitative care.

The possibilities inherent in rehabilitative care for all disabled persons and the benefits to the patient himself, his family and the community have been well documented.

In spite of the considerable amount of knowledge about rehabilitation, its concepts and techniques are usually not employed effectively in the care of the disabled. There are undoubtedly a number of reasons for this lag between knowledge and practice, and for the hesitancy in applying rehabilitative techniques of proven value. Among the more important of these reasons seems to be the widespread idea that rehabilitation can be accomplished only in large general hospitals or rehabilitation centers with a corps of highly trained specialists. This idea probably gained credence from the fact that most of the early development of rehabilitation took place in large hospitals and rehabilitation centers primarily with severely disabled patients, such as para- and quadriplegics, who do require specialized, intensive inpatient treatment. The rapid growth of rehabilitation facilities may have furthered this idea, and perhaps additional support was given by the strenuous attempts of the various professional disciplines to define their roles in the rehabilitation process.

It has been repeatedly shown that the challenges of rehabilitation to every community can be met successfully in most cases simply by using the services and personnel already present in the community or available to it. Even in the more rural areas of Wisconsin where resources may be limited, the majority of the disabled can find the assistance they need to regain and maintain useful and satisfying lives consistent with their potentials. This concept is not new and it does not ignore the importance of treatment centers. It merely asserts that coordinated, rehabilitation-oriented care through existing community resources can be eminently effective in returning the disabled to their optimal levels of function.

Successful rehabilitation in a community is dependent in large measure on the patient's physician. Through his awareness of his patient's total needs and potential levels of achievement, the physician can utilize those community resources essential in meeting specific needs. The physician can also provide leadership and support to programs aimed at developing an understanding of the concepts and practice of rehabilitation-oriented care among all of those concerned with disabled persons. This awareness and support has been a significant factor in the success of the State Board of Health's training programs for nursing personnel in rehabilitative nursing.

Community-oriented programs in rehabilitative nursing in addition to developing skills have been found to be highly successful in helping nursing personnel in the various agencies to become more aware of the nurses' role in the rehabilitative process and of the community resources now available.

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LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin.

1. **Interprofessional Code**
   An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

2. **Civil Defense Manual for Mobile Medical Team Personnel**
   An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.

3. **Code of Necropsy Procedure**
   A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

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   Some recommended standards and principles for providing a hearing conservation program in industry.

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   General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.

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13. **Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959**
    Relating to fee splitting between physicians and others.

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    A reprint of three Wisconsin Medical Journal articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

15. **Guide to The Service Corporation Law**
    A series of questions and answers describing Chapter 350, Laws of Wisconsin, 1961, allowing physicians, among others, to form private medical corporations for the tax benefit of their stockholders.

NOTE: The January Blue Book issue of the Wisconsin Medical Journal is a handy reference on medico-legal subjects. Keep this issue and refer to it often.

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COMMENTS ON TREATMENT

Renal Excretion of Drugs

A Basic Concept with Certain Practical Implications

By F. E. SHIDEMAN, M. D.
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IT HAS BEEN 20 years since Smull and associates[1] first observed that lower serum levels of salicylate follow the administration of sodium bicarbonate with sodium salicylate than when sodium salicylate is given alone. This observation has been confirmed several times since and the use of solutions of alkalinizing agents, e.g., sodium bicarbonate, sodium lactate, sodium acetate, has been accepted as an effective measure in the treatment of salicylate poisoning. The mechanism involved in the action of these agents is an enhancement of the renal excretion of salicylate. Inasmuch as administration of ammonium chloride was observed to reduce the excretion of salicylate, it soon became apparent that the renal clearance of the drug is markedly influenced by the pH of the urine. It was assumed that changes in pH exerted their effects by altering the degree of ionization of salicylate in the tubular urine, but no satisfactory explanation of the basic phenomena involved was forthcoming until recently.

The work of Weiner, Washington and Mudge[2] has clearly demonstrated that the renal excretion of salicylate involves three basic processes: (1) glomerular filtration, (2) active tubular secretion, and (3) passive pH dependent tubular reabsorption. Evidence for tubular secretion of an active nature derives from experiments demonstrating that (1) the amount of salicylate excreted can be in excess of the amount filtered and (2) the secretory contribution to total excretion can be depressed by substances which are themselves secreted, e.g., p-aminohippuric acid, acetazolamide, and by other agents, e.g., probenecid, benzmalecene, which suppress the active tubular secretion of various organic acids, such as p-aminohippurate. The action of these agents is evident under conditions of constant urinary pH and glomerular filtration rate.

Passive pH dependent tubular reabsorption of salicylate is conceived as being the result of impermeability of the renal tubular epithelium to the ionized form of salicylate and complete permeability to the unionized form of this weak electrolyte. The permeable (unionized) form, therefore, tends to reach concentration equilibrium on both sides (luminal and parenchymal) of the tubular epithelium. If the pH on one side of the membrane is more favorable to the dissociation of the drug, more total drug (ionized and unionized) will accumulate on that side, although the concentration of unionized drug will tend to be the same on both sides of the membrane. In the case of salicylate, alkalinization of the urine will increase the concentration of ionized drug in the tubular lumen and acidification will decrease the concentration of this form of salicylate in tubular urine. In other words, a pH greater than that of blood will result in a greater concentration of ionized and total salicylate in the urine and a pH of the urine less than that of blood has the opposite effect. Small changes in urinary pH in the appropriate range can cause marked alterations in the rate of excretion. As an example, an increase in urinary pH from 6.0 to 7.7 causes approximately a tenfold increase in the rate of renal elimination of salicylate. Other weak organic acids with appropriate dissociation constants may be similarly handled by the kidney. This has been shown to be the case with probenecid, p-hydroxybenzoate, salicylurate and

chlorpenol red. A drug which is not actively secreted but which exhibits pH dependent passive reabsorption is phenobarbital. Here, again, the excretion of this compound can be markedly influenced by urinary pH, alkalinization promoting excretion and acidification reducing excretion.

That a mechanism like that described above can operate in the case of weak organic bases, e.g. certain alkaloids, has recently been demonstrated by Peters.[3] Here, however, the effect of urinary pH on excretion of these compounds is reversed but the mechanism involved is essentially the same. In the presence of an acid urine their excretion is enhanced, whereas alkalinization reduces their renal excretion. Mecamylamine is an example of such a drug whose excretion varies inversely with urine pH. Other agents which appear to be handled in the same manner by the kidney include quinine and quinacrine. Undoubtedly there are many more.

This somewhat extensive but incomplete discussion is justified in the writer's mind by his belief that a rational and logical approach to therapy is much preferred to an empirical one. Although the use of alkalinizing agents to enhance excretion of salicylate in cases of intoxication with this agent is well established, it should be borne in mind that the basic mechanism underlying this relatively simple therapeutic procedure can apply to other drugs. This knowledge should allow one to anticipate its possible usefulness under appropriate circumstances and its application to the benefit of the patient.

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ROENTGEN RIDDLE *continued from page 612*

DISCUSSION: The findings on the chest film were compatible with congestive heart failure, bilateral pleural effusion and the so-called "pseudo" or vanishing tumor. Radiographically, fluid in the chest can be shown to be present, but whether it is transudate, exudate, blood, or chyle can only be inferred by associated findings and history. Pleural effusion has many etiologies. A transudate secondary to congestive heart failure is the common type. Too often the pleural cavity is thought to be between the chest wall and the lung only, but the pleural space consists of areas between the various lobes, the lung and the diaphragm, and the lung and the mediastinum. It is not unreasonable to assume that effusion may be found in one of these areas. Further, the fluid may become encapsulated. This comes about from previous adhesions limiting the fluid from collecting in the most dependent portions of the pleural space. The encapsulation of transudates is not unusual.

The radiographic appearance is characterized by a dense, homogenous shadow without internal structure and sharply demarcated. In the present case, the fluid has become encapsulated in the horizontal or minor fissure. The lateral chest film will show this to be superimposed on the cardiac shadow or just immediately posterior. Since with proper therapy it will generally disappear, aspiration attempts of this particular loculation is contraindicated because of the fluid's location.

PRESIDENT'S PAGE

"No More to Build On There"

"BOY, 3, IS KILLED BY CORN CHOPPER."

THIS SHOCKING news item appeared recently in a local newspaper. Reports of similar accidents appear regularly in many other newspapers. This particular accident is especially disturbing because it, like so many, was preventable.

To many people unfamiliar with the problem, farming is a pleasant idyllic occupation with rolling green fields, horses kicking up their heels in the paddock, growing crops and fattening cattle. Although the hours may be long and the responsibility great (for animals need feed, and cows require milking twice daily), many feel that through it all the farmer smokes his pipe and is lord and master of his domain. He is the rugged individualist, the last of his breed as was Uncas, son of Chingachgook, in the "Last of the Mohicans." But as peace and war both have their hazards, so farming due to increased mechanization rivals and often surpasses industry in the growing record of accidents. In the general industrial field great strides have been made in accident prevention with the assistance of the medical profession, but the same cannot be said in the farming industry. In recent years industry has been aggressive in controlling the accident rate. This resulted from a growing social responsibility as well as the necessity imposed by legislative action which made these controls of prime importance from the dollar competitive position. Time loss, medical and hospital care of occupational accidents, and partial or permanent disability payments have all influenced production costs and come under the close scrutiny of various insurance carriers working in cooperation with industry.

But who speaks for the farmer or the farm employee? Who is safety conscious over the loss of life and limb of babies and young farm children? Too often farm youngsters 8 to 14 years of age are operating tractors and potentially dangerous mechanical devices that are proscribed in any other type of work.

Poet Robert Frost in his moving poem "Out, Out" writes about the small Vermont boy cutting wood on a buzz-saw. The boy's sister has just come out to call him to supper.

> "----------, at the word, the saw,
> As if to prove saws know what supper meant,
> Leaped out at the boy's hand, or seemed to leap—
> He must have given the hand. However it was,
> Neither refused the meeting. But the hand!"

And then, in the throbbing ending he tells us,

> "The doctor put him in the dark of ether.
> He lay and puffed his lips out with his breath
> And then—the watcher at his pulse took fright.
> No one believed. They listened at his heart.
> Little—less—nothing!—And that ended it.
> No more to build on there. And they, since they
> Were not the one dead, turned to their affairs."

The National Safety Council reports that in 1960 farming stood third in the rank of deaths per 100,000 workers in all occupations, the honor for first place was mining and next was the construction field. Of the 13,800 workers killed on the job in all industries in that year, approximately 3,300 were killed in farm work. This was actually more deaths than occurred in any other major industry. Disabling injuries of farm residents in the same year and for each year in the past decade average one million per year.

This is a waste—more than that the figures are shocking. How can we bridle this monstrous waste? The medical profession would do well to lend the same help and advice to the farming occupation in accident prevention and safety measures as it has done so well in industry and other occupations.

Although some may feel that farming like virtue is its own reward, the recorded evidence above bespeaks a sad one.

Leigh H. Lockhart

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EDITORIALS

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The Keys to Quackery

DR. WILLIAM H. GORDON of Lubbock, Texas, presented a thought-provoking speech at the Conference on Medical Quackery held recently in Washington, D. C. The following are some excerpts from that speech.

* * *

"Alice: 'One can't believe impossible things . . .
White Queen: 'I daresay you haven't had much practice . . .
When I was your age . .. I believed as many as six impossible things before breakfast.' "
Lewis Carroll *Through the Looking Glass*

"Once upon a time . . . "

No fairy story could possibly have a happy ending unless it is started with "Once upon a time." With this magic phrase one brushes aside the curtain of reality and opens wide the portal leading into the bright, glittering world of make-believe where wishes come true, hope is rewarded and faith is a necessity.

How then could one better start a story about medical quackery than to say, "Once upon a time . . . ?" Without hope, faith, and desperate longing, the entire false world of the quack would collapse. It is a sad commentary that they do work for him, and villain that he is, he tragically exploits faith, mocks the wishful, and holds out hope when he knows there is no hope. Through the employment of infinite cunning, he lures his victim to his domain of quackdom, but each unfortunate dupe must open the door with his own key. One can never lose sight of this fact, the victim opens the door himself. He may be deceived, lied to and cajoled; he may have the key placed in his hand, but he, and he alone, uses it. One may say that without the victim's full consent, he can never enter the land of the sorcerer.

* * *

Any superficial appraisal of this situation where suckers jockey for position to be cheated is apt to be disgusting—or even sickening. Yet, if one should analyze the problem more thoroughly, he might experience other emotions—even pity.

It behooves all who are interested in this widespread and deeply rooted cancer of society to do *more* than tabulate the dollars lost, or enumerate instances of fraud. It *is* im-

portant that more effective statutes be available—more laws which offer fewer possibilities for evasion and escape, and it is imperative that appropriations be sufficient, or at least more realistic. Perhaps greater latitude should be granted the investigators who, without fanfare, laboriously, patiently, and with great ingenuity, trap these enemies of mankind. To repeat, these and other measures are all significant, but it is imperative that an appraisal be made of the basic psychological motives which make quackery possible.

* * *

People living in the United States today profess a high level of civilization, yet at times this culture appears as a thin veneer spread over eons of primitive beliefs. How else can one explain the action of an otherwise reasonably intelligent person who, in times of panic, turns his back on the gifts of modern science and embraces the promises held out by the modern counterpart of the primitive medical men. He hears the song of the Lorelei and hastens to his sorrow, and often to his destruction.

Fear and panic, therefore, constitute two of the charlatan's chief benefactors. They open the door for many.

* * *

One should not make the mistake of believing that only the ignorant react to suggestion. As Dr. Osler stated, "In all matters relating to disease, credulity remains a permanent fact uninfluenced by civilization or education."

It would appear that the elimination of quackery from our society will be accomplished only when the charlatans are removed. It is unrealistic to expect that the public will reject their advances. The keys of hope, fear, longing and desperation influence human action more profoundly than do reason, education or social mores. The hope of accomplishing the impossible remains. Magic continues to be felt by a whole race of humans who knew and responded to its pull long before they called themselves civilized, and will continue to do so despite their thin veneer. The door opens easily when the keys fit the lock.

one of a series

Medical Stamps

CHARLES
LOUIS
LAVERAN
(1845–1922)

A French physician and bacteriologist. While in Algeria in 1878–83, he discovered (1880) the parasite which causes malarial fever. Army physician in 1891–97. In 1907 he won the Nobel prize for medicine and physiology. Professor of military hygiene and clinical medicine. Wrote on sleeping sickness, and on mosquitoes with relation to epidemics. Algeria honored him on a stamp in 1953. # 252.

ACKNOWLEDGMENT: Reproduced by permission of Oscar Gottfried, New York City, author of "Doctors Philatelic," bibliography of nearly 300 illustrative medical stamps, which is available at $3.00 from The New York Physician, 1440 Broadway, New York 18, N. Y.

• • •

Physicians interested in obtaining medical stamp displays for exhibit purposes, write Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin.

THE MEDICAL FORUM

Registration Of All State Radiation Sources Now Underway With Deadline January 1, 1962

Registration of all radiation sources in the state began in mid-November with all physicians, plus others who work with radiation sources, receiving the forms from the Industrial Commission.

The mailing from the Commission included a copy of the law—passed by the 1961 Legislature—which requires the registration, a page of instructions, and the registration form.

Only exemptions from the registration, according to R. G. Knutson, a member of the Industrial Commission, are sources licensed by the Atomic Energy Commission.

Although the Commission was granted power to exempt any source or installation which it finds does not constitute undue radiation hazard, no such exemptions have thus far been listed.

Fee for the registration has been set at $5.

The registration forms, one page in length, call for:

1. Names and addresses of the owner, user and person responsible for radiation safety.
2. Type of source.
3. Application.
4. List of machines and maximum kilovolt peak.
5. Maximum milliamperes.
6. Source strength of radium, and whether sealed or unsealed.

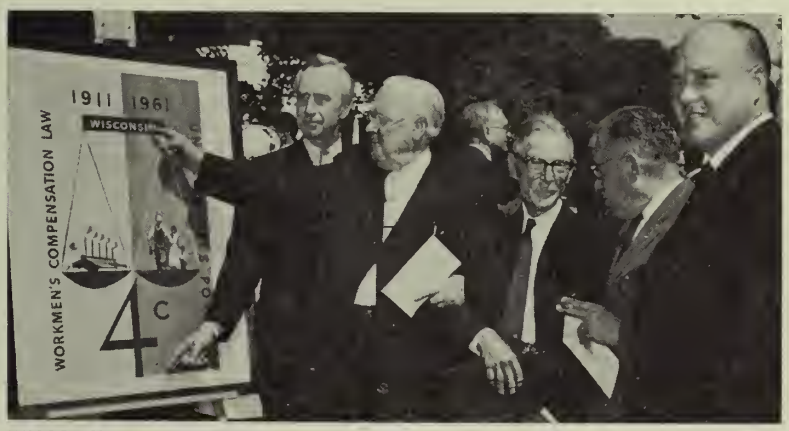
The Industrial Commission has asked that the forms be returned by December 15. The new law requires that all sources be registered by January 1, 1962.

Failure to register by that date could bring a fine up to $500, imprisonment up to 6 months, or both.

One copy of the registration form will be returned to the person sending it in, to serve as a receipt and confirm registration.

Implementation of the registration is being accomplished by the Industrial Commission, with the guidance of an Advisory Committee on Radiation, formed about a year ago.

The Commission is consulting with the State Board of Health in establishing and maintaining the system of registration, and both will report independently to the 1963 Legislature.



WISCONSIN'S WORKMEN'S COMPENSATION LAW, the first in the nation, came in for special attention with the issuance of a special commemorative stamp on the 50th anniversary of its enactment. Pointing to a large replica of the stamp during a special ceremony in Washington, D. C., are Rep. Vernon W. Thomson, Richland Center, and Sen. Alexander Wiley, Chippewa Falls. In the center are Theodore Brazeau, Wisconsin Rapids, member of the Legislature when the law was passed, and Jacob Friedrick, President, Milwaukee County Labor Council. On the far right is Rep. Melvin Laird, Marshfield. The stamp enlargement is now on display at the State Medical Society office.

Visual and Hearing Division Lists Two New Sub-Committees

Appointment of two new sub-committees has been announced by Dr. Meyer S. Fox, Milwaukee, chairman of the Division on Visual and Hearing Defects of the Commission on State Departments.

Appointed to the new sub-committee on Visual Problems are:

John B. Hitz, M.D., Milwaukee, Chairman
Donald A. Peterson, M.D., Madison
James V. Bolger, M.D., Milwaukee
E. George Nadeau, Jr., M.D., Green Bay
C. G. Reznichek, M.D., Madison

On the new sub-committee on Ear, Nose and Throat are:

Meyer S. Fox, M.D., Milwaukee, Chairman
Roger H. Brodhead, M.D., Wausau
Sidney B. Russell, M.D., Eau Claire
Richard J. Fogle, M.D., Racine
C. G. Reznichek, M.D., Madison

Philosophy Of Kerr–Mills Care For Aged Backed By Many Wisconsin Organizations

What is the Kerr-Mills philosophy?

Welfare Director Wilbur Schmidt recently summed it up in a statement before the Joint Committee on Finance of the Wisconsin Legislature.

"The philosophy, as we see it, is that there are among the aged population those who might be prevented in the long run from going to total dependence on old age assistance if they could have something standing in back of them . . . at a point where they are experiencing catastrophic medical expense and give some help to them so as not to exhaust their assets.

"And, secondly, it may well be that the health of the community, especially among this aged group, which constitutes the source of a considerable amount of expense ultimately, might be neglected by some of the elderly people because they are not obtaining medical care in the thought that they are unable to afford it."

QUOTES ESTIMATES

Schmidt estimates that of the 400,000 people in the state who are over 65 years of age, 175,000 could qualify under programs proposed to the legislature. Of these, his department feels some 20,000 persons would receive benefits in a year's time.

The program would cost an estimated $10,000,000 a year, with $5,300,000 coming from the Federal government and $4,700,000 from the state.

The above figures are based on two of the three measures placed before the legislature during its late session which started October 31. One of the measures, Substitute Amendment 3, A., to Bill 550, A., has been drafted and supported by the State Medical Society.

Among those supporting this proposal, at a hearing November 1, were the Wisconsin Farm Bureau Federation, Wisconsin Pharmaceutical Association, Wisconsin Hospital Association and Wisconsin State Dental Society.

ELIGIBILITY

Who would be eligible? Following are the criteria a person would have to meet:

1. Be 65 years of age or older.
2. Cannot be a current recipient of Old Age Assistance.
3. Must make a sworn statement that his annual income if he is single is $1,500 a year or less, and if married is $2,500 or less. A person with a higher income may become eligible if income over the stated figure has been used up in health care expense or payment of health insurance covering him or his spouse.
4. Does not have cash or other liquid assets above $4,500 if single or $7,500 if married. He may own a home and related personal property including an automobile.

Safeguards include a provision for recovery of benefits from the estate of a recipient after his death, though a lien may not be placed on his property during his lifetime, and a penalty for falsely submitting the affidavit on income and assets.

COVERED SERVICES

Under the bill the Department of Public Welfare, as administrator of the program, would be authorized to provide payment for part or all charges for:

1. **In-patient hospital services.**
2. **Professional services of the dentist and the physician in a hospital or in a skilled nursing home.**
3. **Diagnostic x-ray and laboratory services.**
4. **Skilled nursing home care as authorized by the physician.**
5. **Services of the physician in the home and in the outpatient department of a hospital.**

In addition, drugs and visiting nurse services are available if the Department of Public Welfare in its judgment feels that there are sufficient funds available.

LIMITATIONS

There are some limitations:

1. There is a 42-day limit for persons in a medical institution for tuberculosis or mental disease.
2. The beneficiary is required to pay a deductible equal to a percentage of his annual income.
3. Benefits are not provided for inmates of public institutions.
4. Nursing home care would be

(Continued on page 627)

CARE OF THE PREMATURE INFANT was the topic of this institute held October 25 at Viroqua. Attending were physicians and nurses from that section of the state. The conference was presented by the Charitable, Educational and Scientific Foundation of the State Medical Society and the Bureau of Material and Child Health of the State Board of Health. Shown on the right is Dr. Thomas V. Geppert, assistant clinical professor of pediatrics, University of Wisconsin Medical School, one of the four speakers on the program.

Many Organizations Support Kerr–Mills Care For The Aged

(Continued from page 626)

paid only after the individual had been transferred to a skilled nursing home care after having been hospitalized.

5. There is a maximum liability on hospital care and skilled nursing home care of 45 days per illness.

Some other important factors written into the bill include: complete free choice of hospital, physician and nursing home; direct payment to the vendor for services; and authorization for Welfare Department to contract with certain organizations to administer the benefits on an insurance basis.

COST TO WISCONSIN

Looking more deeply into the finances, the cost each year is estimated at $10,000,000 with the state share coming to $4,700,000 in matching funds and $250,000 for administration. Under another portion of the Kerr-Mills Act, Wisconsin receives annually $2,672,000 to apply to its existing Old Age Assistance Program. The intent here was to upgrade these programs in the states, but since Wisconsin already has one of the best in the nation this amount was turned over to the counties to relieve them of some of their costs in the present program.

In future years, this could be applied to the second portion of the Kerr-Mills Act, bringing the amount of "new" Wisconsin money needed down to $2,300,000.

PHYSICIANS SPEAK

In support of the Kerr-Mills concept, Dr. Nels A. Hill, Madison, president-elect of the State Medical Society, said, "I think that passage . . . in Wisconsin will keep thousands of elderly off relief, that it will give them help with their health care expense without the necessity of becoming a 'relief' case."

"We must not shunt them aside into some broad category of population labeled: 'These are old people who can't take care of themselves. They must be taken care of by the government'," he added.

Dr. Robin N. Allin, Madison, chairman of the State Medical Society's Committee on Health Economics of American Life, has spoken out even more strongly:

"We don't want a monstrous Federal program providing benefits to everyone regardless of their needs," he said. "We do want sound health care for those aged who cannot meet its expense on their own. Speaking as a physician I feel we should implement the Kerr-Mills Act in Wisconsin."

RETAIN TRADITIONAL CONCEPT

Speaking for the Wisconsin Farm Bureau Federation, William KasaKaitas had this to say about Kerr-Mills:

"We believe that Wisconsin should initiate a program in this area as provided in Bill 550, A."

"Unless we prepare to deal with these problems ourselves, on a realistic basis, we are inviting the Federal government to prescribe programs which would abandon the traditional concept that medical care should be provided without cost only to those who lack the means to pay for it themselves."

To date, the Kerr-Mills Act has been implemented in 27 states and territories.

Crash Injury Study May Be Expanded To Include Seat Belts

Wisconsin's new seat belt law —requiring installation of the safety devices in 1962 and later models—may result in expansion of the study now being conducted in the state by Automotive Crash Injury Research of Cornell University.

The possibility was discussed in a recent visit by Robert A. Wolf, New York, director of the research unit.

Wolf was in Madison regarding the present study being carried out with the cooperation of the State Medical Society, State Board of Health, Motor Vehicle Department, and Wisconsin Hospital Association.

He said that over 100 injury-producing accidents had been recorded in the study being carried out in the eastern portion of the state. Statistics from these cases have not yet been tabulated.

On January 1, the study will shift to the western half of the state; and on July 1, 1962, the entire state will be covered for injury-producing accidents involving 1957 or later model vehicles.

Under the program the State Highway Patrol, physicians and hospitals cooperate by making detailed reports on crashes and the injuries they produce. These are forwarded to the State Board of Health and then to Cornell University.

Purpose of the study is to bring about redesign of autos to lessen or eliminate danger of injury in case of accident.

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Civil Defense Medical Teams Progressing But Some Areas Need Medical Directors

Plan Teaching Program For Medical Self-Help

Wisconsin's immediate Civil Defense problem is to build effective organization at all levels, William K. *Chipman*, Madison, State Director of Civil Defense, told the members of the State Medical Society's Committee on Disaster Medical Care October 12.

Chipman met with the committee to outline the current national and state programs, and explore a proposed medical self-help training program designed by the Public Health Service.

J. S. WIER, M.D.
Chairman, Committee On Disaster Medical Care

PRESENT STATUS

From reports given at the meeting, it appears a good portion of the state is organized for Civil Defense functions in medical fields:

1. At present there are 27 mobile teams capable of mobilization in case of emergency. These are located mainly in smaller communities.
2. Eleven additional 200-bed emergency hospitals were installed in the state last year, bringing the total to 56. Wisconsin has requested 14 more for 1962, and if federal financial aid for rental of storage space becomes available, 30 more will be requested. About 50 percent of the present hospitals have administrators and chiefs of staff assigned.
3. There are now 53 county medical directors in the state.
4. Some 40 emergency treatment stations have been established in the state, and casualty evacuation capability is being added to these stations.
5. The state is purchasing 30 sets of emergency blood procurement supplies. In addition, the state has 19,628 PVP injections in storage at Camp Williams and 4,370 units of dried blood plasma which will be fractionated into normal serum albumin for storage around the state.

SELF-HELP PROGRAM

Some problems were seen concerning implementation of the Medical Self-Help Training Program in Wisconsin.

The program, developed over a two-year period by the PHS, is designed to teach families how to survive a national emergency and meet their own health needs if a physician is not available.

Ultimate objective is to instruct one person in each family on basic medical skills under the supervision of trained lay instructors.

Subjects include: radioactive fallout and shelter; hygiene, sanitation and vermin control; water and food; artificial respiration; bleeding and bandaging; fractures and splinting; burns and shock; transportation of the injured; nursing care of the sick and injured; infant and child care; and emergency childbirth.

COUNTY SOCIETIES ASKED TO HELP

William K. *Chipman*, State Director of Civil Defense, outlined three methods by which county medical societies could be of immediate assistance to his organization in CD activities:

1. **Give out information on Civil Defense, through individual physicians, to patients and other contacts.**
2. **Furnish physician speakers for lay meetings on Civil Defense.**
3. **Contact County Board members to impress them with the importance of the Civil Defense program, particularly in counties where organization is lax.**

Available Publications on Civil Defense

The following pamphlets, of use to the general public for Civil Defense planning, are available from your city or county Civil Defense director. If he does not have them on hand, he may order them cost free from the State Civil Defense Office:

"First Aid—(L–2–12)—giving basic first aid instructions and listing the recommended first aid items to be stored in a family fallout shelter area.

"The Family Fallout Shelter"—(MP–15)—explaining the need for shelters, how to live in them, and giving basic plans for constructing various types of shelters.

"Individual and Family Preparedness"—(NP–2–1)— outlining the steps a family can take to prepare for a disaster and giving a recommended food supply to be maintained in the shelter area.

"Home Protection Exercises"—(MP–1)—lists eight exercises a family can perform in such areas as preparation of a shelter, fire prevention and fire fighting, emergency action, provision of safe food and water, and home nursing. Assigns individual family members to duties.

(If supplies of these pamphlets are not available through your local Civil Defense organizations, contact the State Medical Society, Box 1109, Madison, Wisconsin.)

SMS AIDS IN FINDING REPLACEMENTS . . .

Sixteen Physicians Answer Call To Service

Increase of the number of men on active duty in our Armed Forces has resulted in 16 physicians leaving their Wisconsin communities, most of them accompanying the 32nd Division.

Following are physicians who have entered the service:

Dr. Conrad P. Reslock, Waupun
Dr. John A. Arkins, Milwaukee
Dr. E. G. Stack, Superior
Dr. John A. Van Susteren, Onalaska
Dr. George T. Mohler, Oconto
Dr. Robert L. Pettera, Rib Lake
Dr. Thomas S. Sargent, Janesville
Dr. D. W. Fink, St. Croix Falls
Dr. James R. Hanson, Madison
Dr. Stanley J. Zeitz, Milwaukee
Dr. Anthony A. Herrmann, Racine
Dr. David W. Westring, Milwaukee
Dr. Richard A. Holmes, Milwaukee
Dr. John C. Manley, Milwaukee
Dr. Joseph D. Lloyd, Milwaukee
Dr. Robert F. Lipo, Wood

In some of the smaller communities, the departure of a physician posed a serious problem—case in point, Doctor Pettera, Rib Lake's only physician.

The State Medical Society had originally helped Rib Lake attract a physician back in 1956, when Doctor Pettera located there, and the Placement Service again swung into action.

Letters went to all the general practitioners on the placement list, and Rib Lake was again placed on the list of available communities. The information was also sent to all medical schools in the country and to the Sears-Roebuck Foundation which operates a placement service with the American Medical Association.

On the local level, Doctor Pettera appeared on the Wausau television station and later on the nationwide "Monitor" radio program. His county medical society offered to care for his patients until a replacement was found.

It was the "Monitor" radio program that eventually paid off. Dr. Frank Hesse, Hudson, Ia., heard the program and contacted the community.

Again the State Medical Society was called, to assist in expediting his licensure in Wisconsin. From information now available, it appears there will be no difficulty in issuance of a temporary license by the State Board of Medical Examiners.

Still pending is the situation at Oconto, where Doctor Mohler was one of three physicians in the community. The Placement Service continues to look for a replacement for that community.

"Doctors In Asia" Plan

Five Tulsa, Oklahoma, physicians are giving up their practices for six-week periods to serve voluntarily in India. The physicians will go to India one at a time, to donate a total of 30 weeks to the "Doctors in Asia" program.

A large number of doctors have written to the A.M.A. in recent months to inquire about such programs.

"March Of Medicine" Program Is Praised By Radio Stations

The "March of Medicine" radio program, produced by the State Medical Society under the direction of the Commission on Public Relations and Communications, recently came in for some kind words from stations which broadcast it.

Says Carl V. Kolata, president and general manager of station WTTN, Watertown:

"Programs produced by your organization are not only good programs generally, but are programs that impart to the listener knowledge they could get nowhere else."

From Clair J. Stone, program director of station WJPG, Green Bay:

"Doctor Tenney and Mr. Schmidt do a wonderful job in making it an interesting program in a manner that is comprehensive to the listener. We are very happy to have it on our schedule."

"March of Medicine," under program director Dr. H. Kent Tenney, Madison, and medical reporter Karl Schmidt, Madison, is now carried over 52 radio stations and affiliates in Wisconsin.

MARCH OF MEDICINE team Karl Schmidt and Dr. H. Kent Tenney, both of Madison, make a few notes using the skeleton at the State Medical Society building for reference. Doctor Tenney is director of the program and Schmidt is medical reporter.

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Inquiries Invited

Medical Museum Attendance 6,940 In 1961

A total of 6,940 persons visited the Museum of Medical Progress at Prairie du Chien during the 1961 site season.

The museum was open May through October for its first full season of operation. It is a project of the Charitable, Educational and Scientific Foundation of the State Medical Society and is operated by the State Historical Society of Wisconsin.

The site ranked fourth in popularity among the five sites operated by the historical society. Attendance topped that at Stonefield, and was behind the figures for the Circus World Museum, Villa Louis and Wade House.

A SUCCESSFUL SEASON ended October 31 for the Museum of Medical Progress at Prairie du Chien. On the left is the new administration building and on the right the restored military hospital of Old Fort Crawford, which houses the exhibits. The museum will reopen next May 1.

QUESTIONS AND ANSWERS ON
MEDICARE

In connection with the recent activation of the 32nd Division, physicians are receiving many requests for information concerning the Medicare Program.

The following appear to be the questions most frequently asked:

1. **Question: Does Medicare have special provisions which apply to the 32nd Division, or has there been a major change in the Medicare Program?**
   Answer: The Medicare Program is identical for all units and for all branches of service. The Medicare *Guide for Physicians,* revision effective January 1, 1960, contains current information.
2. **Question: Have there been any changes in Medicare provisions since January 1, 1960?**
   Answer: Changes, or clarifications, have been distributed on three items—immunizations, drugs, and post partum care.
   a. Polio immunizations administered parenterally to obstetrical patients have been ruled as payable **only to the extent of the cost of serum to the physician.** In addition to this, beginning with claims paid on and after November 1, 1961 bearing a "From" date not earlier than March 1, 1961, **influenza immunizations** administered parenterally to obstetrical patients are also payable **to the extent of the cost of the serum to the physician.**
   b. Item 7, Page 11, of the Medicare Guide is expanded by insertion of the following sentence; "Parenterally administered drugs are also payable if directly associated with the proper care of surgery authorized under Medicare, but this does **not** authorize payment for such drugs used in the **medical treatment** of a condition, even when surgery may eventually be performed."
   c. Postpartum visits were formerly payable only if performed within 6 weeks following delivery. This limitation is now extended to 8 weeks. However, payment for out-patient treatment of complications following delivery can be made **only** when the treatment is started within 6 weeks. If started within 6 weeks, payment is authorized until care is completed. Routine postnatal visits completed after 8 weeks or out-patient care of complications commencing after 6 weeks are the financial responsibility of the patient or sponsor.

(Continued on page 632)

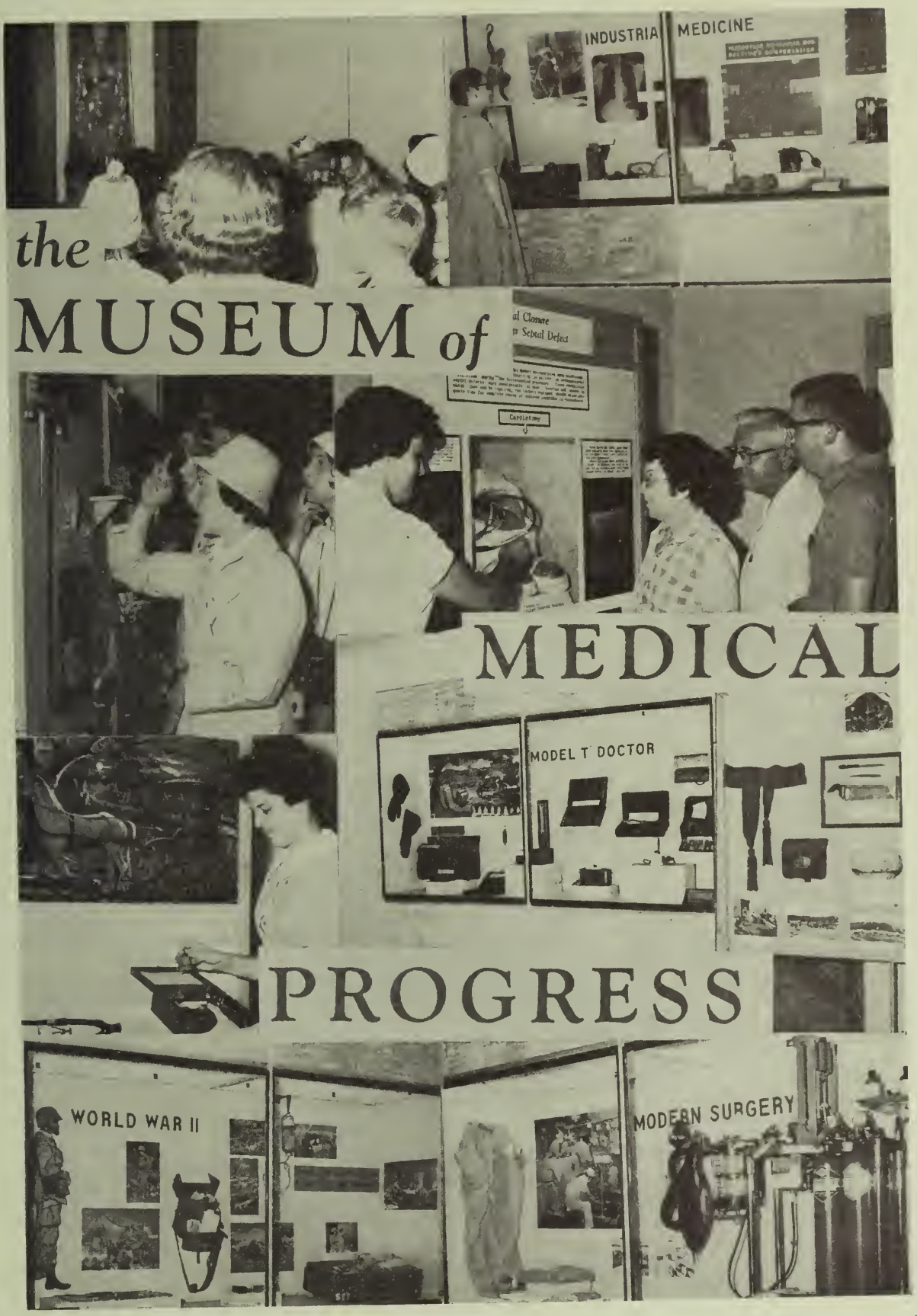
A panorama of views of the Museum of Medical Progress is shown on the next page. The exhibits proved popular to all age groups, with a number of school children visiting the site during the year to learn about the history of medicine and the progress over the past centuries which has brought the level of health care they enjoy today.

WISCONSIN DELEGATE PRESIDENT-ELECT OF MEDICAL ASSISTANTS

Alice Budny, Milwaukee, was installed as president-elect of the American Association of Medical Assistants at its fifth national convention October 13–15 in Reno, Nevada.

Miss Budny will be installed as president at the 1962 meeting of the AAMA, which now has 30 state chapters with more than 9,500 members.

the MUSEUM of MEDICAL PROGRESS



Dr. Robert S. Monk New Member of SMS Committee On Cancer

Dr. Robert S. Monk, Waukesha, has been appointed to the Committee on Cancer of the State Medical Society by President Dr. Leif H. Lokvam.

Doctor Monk will fill the vacancy created by the death of Dr. Raymond P. Welbourne, Watertown. The term runs until 1963.

As a member of the State Medical Society committee, Doctor Monk will also serve on the board of directors of the Wisconsin Division, American Cancer Society.

SPECIAL RECOGNITION of Wisconsin's high regard for Dr. William D. Stovall was demonstrated in the October *Wisconsin Medical Journal*, which was dedicated in his honor. Here Doctor Stovall receives the first copy of the issue from Dr. G. A. Cooper, Madison, member of the editorial board.

Shortage Of Nurses Seen By Director

Recruitment of professional nurses in Wisconsin is lagging behind the rate in the rest of the country and prospects for improvement in the supply are not good, according to Adele G. *Stahl*, director, State Department of Nursing.

During the last five years enrollment in Wisconsin schools of professional nursing declined by one-fifth, she stated. In addition, the shortage of qualified teachers makes it unlikely the Wisconsin nurse production can be increased significantly.

QUESTIONS AND ANWERS ON

MEDICARE

(Continued from page 630)

3. **Question: When do the dependents of servicemen become eligible for Medicare benefits?**
   Answer: Assuming patient is an eligible dependent and the sponsor is assigned to a period of active duty in excess of 30 days, his benefits begin with any service rendered on or after the day the serviceman enters active duty. Costs incurred prior to the entry date are not covered by Medicare, whether or not they have been billed previously. For example, the serviceman's wife who received prenatal care prior to the husband's entry into active duty is responsible for the costs of such care, even though Medicare benefits will be available for prenatal care, for delivery, and for post-natal care still to be performed after the date of entry into active duty.
4. **Question: Does Medicare cover any services other than those rendered to a hospital bed patient?**
   Answer: Such benefits are limited but the following are allowed:
   a. Prenatal care and postnatal care of the mother. (See 2 above.)
   b. Treatment of bodily injuries, including diagnostic tests and procedures. These are limited to fractures, dislocations, lacerations or wounds.
   c. Pre- and post-hospitalization tests and procedures for diagnosis and evaluation necessary for proper management of bodily injuries and surgical procedures only, with maximum $75 preceding and $50 following hospitalization. Purely diagnostic services not related to survery or injury are not covered.
5. **Question: Are there other developments with which doctors' offices should be familiar?**
   Answer: It has come to our attention that some dependents of 32nd Division servicemen have been issued Identification Cards which do not show an Expiration Date but instead carry the word "Indefinite." The Medicare office is not allowed to pay claims on this basis, and it is required that the sponsor must provide a letter in duplicate (one copy for the doctors' claims and one for the hospital), dated and signed by an officer of his unit, stating the date the sponsor began active duty and showing either that he is still on active duty or the date of his discharge. Your patience and assistance until such time as this situation can be corrected by the military units involved will be appreciated.

For further details on these and other questions, refer to the Medicare *Guide for Physicians*, copies of which were distributed to all Wisconsin physicians several months ago.

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ROBERT N. RANDALL • *Executive Director* • AL 7–2012

the Wisconsin Medical Journal

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Spontaneous Cure of Epidermoid Carcinoma with Widespread Metastases

By ANTHONY C. SCHNAPP, M. D., and WILLIAM J. BLAKE, M. D.

Milwaukee, Wisconsin

WHILE SPONTANEOUS regression of cancer is not unheard of, nevertheless it occurs infrequently enough in one practice to warrant reporting.

The occurrence of spontaneous regression of cancer has been estimated by Bashford[1] as once in 100,000 cases and by Boyers[2] as once in 80,000 cases. Some authorities doubt that this phenomenon ever occurs. Stewart[3] has defined spontaneous regression of cancer as the partial or complete disappearance of a malignant tumor in the absence of all treatment, or in the presence of therapy which is considered inadequate to exert a significant influence on neoplastic disease.

Everson and Cole[4] in an exhaustive and critical study, have reviewed over 600 cases of spontaneous malignancy regression, but of these have considered only 47 cases to have adequate documentation including histologic confirmation of the malignancy.

In Everson and Cole's series of 47 cases were included: 10 neuroblastoma, 8 bladder (urinary), 5 malignant melanoma, 4 breast, 4 soft tissue sarcoma, 2 colon and rectum, 2 kidney, 2 metastatic carcinoma—primary unknown, 2 oral cavity, 2 ovary, 2 uterus, 1 lung, 1 osteogenic sarcoma, 1 pancreas, and 1 stomach.

While malignancy and its causes are an intriguing and thought-provoking problem, the cause or causes of spontaneous regression of cancer is even more elusive. Some of the possible factors thought by many to be responsible for this phenomenon are: (1) interference with nutrition of the tumor, (2) endocrine influences, (3) hypersensitivity to inadequate therapy, (4) removal of carcinogenic agent, (5) acute infections, and (6) allergic reactions.

Case Report

The patient, a 40-year-old truck driver, was first admitted to St. Luke's Hospital on October 15, 1950. His chief complaint was low back pain radiating to the left leg. He stated that he had had the same symptoms four years previously and that they had been treated by heat and traction. He admitted being a smoker and a moderate drinker. A complete physical examination was negative. The diagnosis was possible herniated in-

From the Department of General Practice, St. Luke's Hospital, Milwaukee.

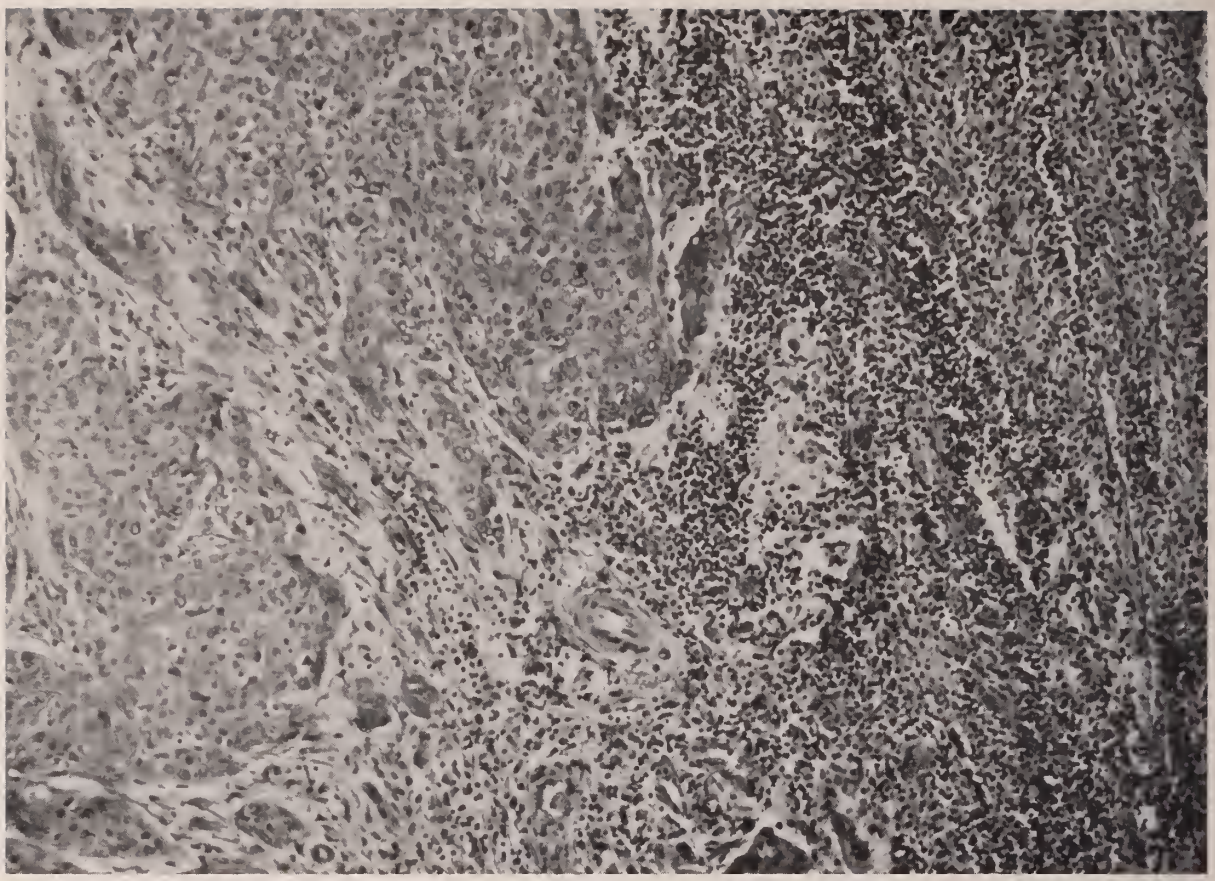

Fig. 1—Note the large masses of tumor cells at the left, displacing the lymphoid tissue. (Approx. X100)

tervertebral disc. Routine laboratory studies were normal except for a neutrophilic leukocytosis of 12,450. A consultant advised conservative treatment by heat and traction. After a few days when heat and traction failed to relieve the pain a body cast was applied.

The patient was discharged but returned on November 6, 1950, with a recurrence of back pain. The left leg muscles were atrophied and weak for which he received physical therapy.

A laminectomy was performed. A large, degenerated disc between L-4 and L-5 was found. This was removed and the patient made an uneventful recovery.

The next admission of the patient to the hospital was on June 7, 1954, when he was 44 years old. He complained of dull pain in the left arm, forearm and shoulder on and off, for six months. In addition to this, for the past four months he had noted a mass in his right inguinal region which had gradually enlarged. There were no fever, chills or nausea. He had taken no medicine. He was afebrile, well developed and well nourished. His blood pressure was 114/72; weight, 148 pounds; and height, 66 inches. He had a hard nodular mass in the right inguinal region, a small cervical lymph node, an enlarged left inguinal lymph node, enlarged, hard bilateral epitrochlear and axillary lymph nodes. The complete blood count was normal; a chest x-ray film was read as negative. The erythrocyte sedimentation rate was within normal range.

A large mass of firm, matted nodes was removed surgically from the right inguinal region. The specimen consisted of three rather lobulated, but roughly spherical masses of tumor tissue, 5 to 3 cm. in diameter. In addition there were four pieces of soft, pink, elastic tissue 1 cm. in diameter each. The larger nodules had uniform surfaces made by cutting, of a gray, granular and friable nature, that grossly resembled metastatic carcinoma. There was yellow necrosis in the large specimen. The microscopic examination showed that all nodes submitted were almost entirely replaced by masses and

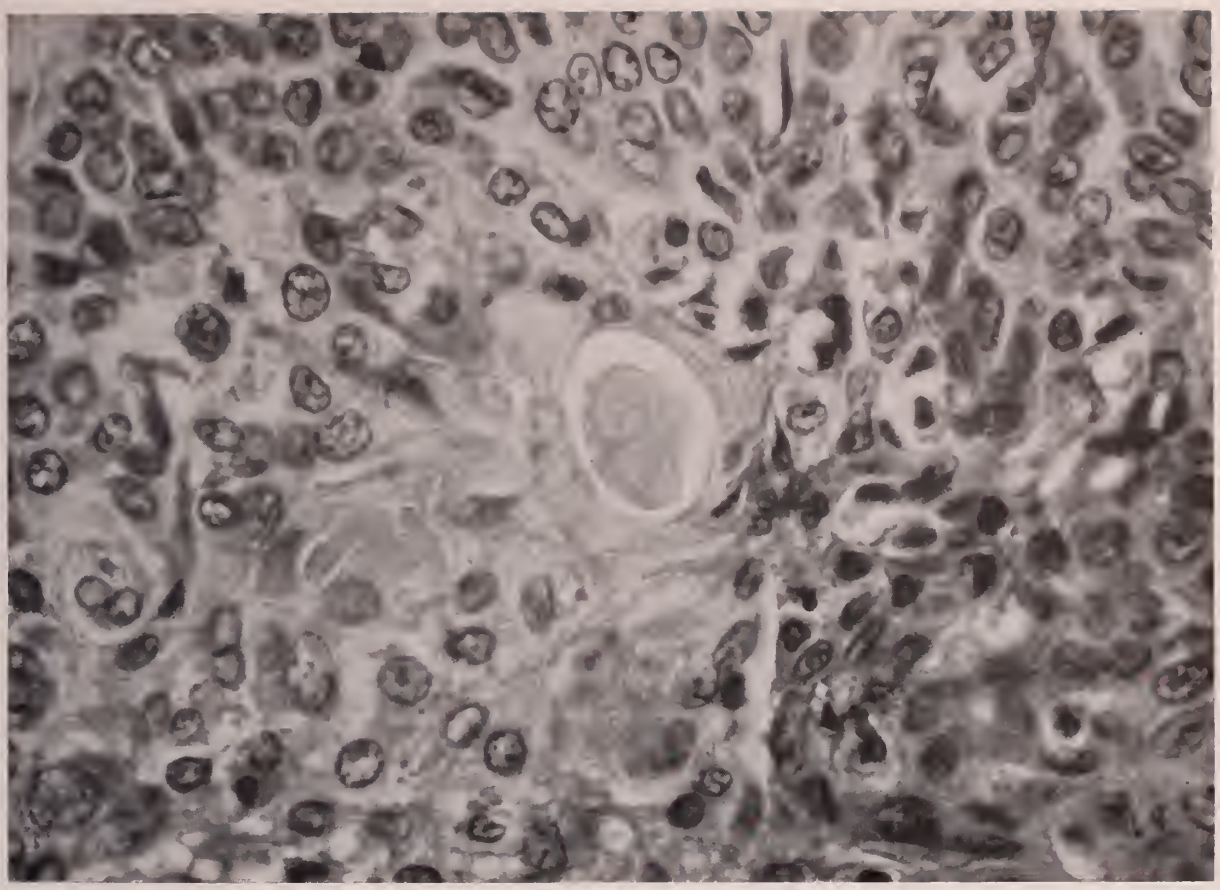

Fig. 2—High power magnification of one of the tumor cell masses, showing a keratin "pearl." (Approx. X500)

cords of neoplastic cells resembling squamous cells (Fig. 1 and 2).

The tumor cells varied greatly in size and shape and in places formed small deposits (pearls) of keratin. The pathologic diagnosis was epidermoid (squamous cell) carcinoma, metastatic, of inguinal lymph nodes.

Upon receiving this report, the attending physician consulted with the pathologist, remarking that the patient's general good health, and the lack of an obvious primary source for such extensive metastatic lesions, tended to throw doubt on the diagnosis. At this time, therefore, a thorough analysis of possible causes of a mix-up of specimens was carried out. It was determined that neither on that day nor any other day during the week, had other lymph nodes been received by the pathologist for diagnosis. Neither had lymph node biopsy been performed either in the outpatient department or in the operating room. Also, from comparing notes on the gross character of the nodes in question, the attending physician and the pathologist could not but agree that the specimen was indeed from the patient, because both observers felt the granular and firm nature of the tissue was outstandingly obvious to both men.

The patient was discharged without treatment of any kind, as it was decided to keep him under observation. Because of the widespread glandular enlargement and the positive diagnosis of malignancy by several pathologists, it was decided to forego the search for the primary lesion. The patient's wife was appraised of the diagnosis and prognosis. She did not inform the patient who to this day is unaware of his condition.

He did not come to the attending physician's attention for some six months, at which time he appeared to be in excellent health. The examiner was impressed with the almost complete disappearance of the glands. When questioned as to whether he had undergone treatment elsewhere, the patient stated that he had had no treatment, medical or radiological, since his discharge from the hospital. He was again admitted to the hospital on September 12, 1956. At this time he had no complaints but entered merely

for re-biopsy of the original site in order to determine what had happened to the metastatic carcinoma previously found in that area. Physical examination was negative except for bilateral axillary nodes. The complete blood count and urinalysis were negative, except for leukocytosis of 11,500 with 7 eosinophils. The hemoglobin was 16.4 gm. per 100 ml. His weight was 140 pounds, his height 64 inches. Several small nodes were removed from the right inguinal region and these were examined by the pathologist, who reported only reactive hyperplasia.

Today, some seven years after the original onset of symptoms of enlarged lymph nodes, the patient is well. He is employed as a truck driver which requires not only driving but also loading and unloading. He is able to perform a full day of hard work, feels strong and has lost no time from his work since 1956. He has had only an occasional upper respiratory infection since 1956 from which he quickly recovered. His weight has remained between 140 and 143 pounds for the past four years.

Summary

A case of spontaneous regression of malignancy has been presented which we believe fulfills the criteria set forth by Stewart.[3] The diagnosis of squamous cell carcinoma was made by several pathologists, on a histologic basis. Some of the probable factors responsible for this phenomenon have been mentioned. This patient is alive and well with no evidence of malignancy seven years after establishment of the diagnosis. No adequate reason can be suggested for his recovery.

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TEN-YEAR EXPERIENCE WITH STAB WOUNDS OF THE HEART

Vollrad J. Von Berg, M.D., Luigi Moggi, M.D., Lyle F. Jacobson, M.D., Prescott Jordan, Jr., M.D., Detroit Receiving Hospital. Abstract from *Journal of the Michigan State Medical Society.* 59:1711 (Nov.) 1960.

As early as 1649, Riolenus suggested pericardial aspirations as a treatment in cardiac injuries and, in 1886, Fischer reported 452 cases of such injuries treated by venesection and aspiration with a case fatality of eighty-four per cent. In 1896, Rehn performed the first successful cardiorrhaphy. Over the years, many series have been presented illustrating the two major philosophies of treatment of cardiac wounds: simple aspiration and surgical treatment. To this controversial subject, we would like to add our experience in which operative intervention has been our treatment of choice.

All patients with the diagnosis of cardiac trauma who were alive on admission are included in this series. Ninety-six of the patients were male and six female; 86 per cent were Negroes and 14 per cent were white. Age distribution followed a normal curve with a peak incidence between thirty-one and forty years. Acute clinical tamponade was present in fifty patients, while the remainder had either hemothorax or hemopericardium of various degrees not sufficiently serious to give acute tamponade. Pericardial aspiration was done on fifty-nine patients, either to confirm diagnosis or relieve tamponade, with positive results in forty-four patients and negative results in fifteen. Eight patients were treated by aspiration alone and in this group one died. The remaining patients with clinical and radiological suspicion of cardiac injury were operated upon even though acute tamponade was not manifest or pericardial aspiration was negative. The locations of cardiac wounds in ninety-two patients operated upon were: right auricle, six; left auricle, six; right ventricle, thirty-nine; left ventricle, thirty-seven; others, nine. Through-and-through lacerations were present in some instances. Five patients had nonpenetrating myocardial lacerations and no cardiac injury was found in three. Active bleeding from the cardiac wound was present in fifty-five, absent in twenty-nine, and unknown in eight. Postoperative complications did not differ from those in any large traumatic series. Specific cardiac complications included cardiac arrest at the time of surgery, ten; arrhythmia, four; pericardial effusion, eight; and preoperative infarct, two. Interventricular septal defect and aortic-ventricular fistula each ensued once after injury (demonstrated by cardiac catheterization). Postoperative electrocardiograms revealed a subepicardial damage in thirty-four patients, pericarditis in twenty-eight and infarct pattern in nine. The over-all survival rate, including eight patients treated by aspiration alone was eighty-nine per cent. Of the thirteen patients who expired, two died before any treatment could be started, five at the time of operation either from exanguination or cardiac arrest, and six from various postoperative complications.

William Beaumont Memorial Lecture

Individualized Selection of Duodenal Ulcer Operations

By JAMES L. A. ROTH, M. D., Ph. D.

Philadelphia, Pennsylvania

UNTIL RECENTLY, partial gastric resection has been regarded generally as the procedure of choice for many patients with complicated or intractable duodenal ulcer disease. An estimated 10% of the total group of duodenal ulcer patients are "given the benefit of" this operation which has been demonstrated by experimental and clinical studies to reduce the secretion of hydrochloric acid and to provide a maximum degree of protection against recurrent ulceration. Inasmuch as operative mortality in the hands of well-trained surgeons is at present no more than 2 to 3%, and less than 1% in some medical centers, the decision about surgical intervention can be made without undue apprehension as to immediate survival. Subtotal gastrectomy, however, may give rise to some unnecessary side effects which usually come to the attention of the internist who follows these cases, rather than the surgeon who performs the operation. Postgastrectomy syndromes have been variously reported to occur in from 10 to 60% of cases.

The objective of surgical intervention as an elective procedure should be not only to prevent ulcer recurrence but also to render the patient free of disabling symptoms with a minimum of pathophysiologic side effects, such as dumping syndrome, malnutrition, diarrhea, vagotomy gastric stasis and the afferent or efferent loop syndromes. Operation must not give rise to physical incapacity or inability to earn a livelihood.

Dissatisfaction with the sequellae of radical subtotal gastrectomies in the past decade has led our physiologically-oriented surgeons to develop new operations, or to re-evaluate older procedures. Hence, there have been published reports on the results of vagotomy with gastroenterostomy, vagotomy with pyloroplasty, gastroduodenostomy or the Billroth I procedure, hemigastrectomy or 50% gastric resection with vagotomy, segmental resections and others. The initial enthusiasm of the proponents of these various procedures has been tempered by the passage of time that permits evaluation of end results in terms of not only mortality and morbidity but also the rate of recurrent ulceration and sequellae. Nevertheless, some value has been demonstrated for each of these surgical procedures, and the application of this knowledge to an individualized selection of ulcer operation is the subject of this presentation.

Physiologic Effects of Ulcer Operations

Prevention of ulcer recurrence is primarily dependent upon adequate reduction in the gastric free acid, which may be accomplished surgically by several methods: (1) through neutralization by facilitating enterogastric regurgitation of the alkaline mucoid secretions of Brunner's glands, bile and pancreatic juice by way of the gastroenterostomy or gastrojejunostomy stoma; (2) through reduction of the secretory capacity of the stomach by removing the parietal cells in resection of the body of the stomach; and (3) through removal of stimuli for acid secretion by complete vagotomy to eliminate the vagus mechanism and its potentiating influences upon the response of other stimuli, or by complete antrectomy to eliminate the gastrin mechanism, or finally in rare circumstances by removing ulcerogenic, pancreatic adenomas popularized by Zollinger and Ellison.

Presented at the Annual Meeting of the Wisconsin State Medical Society, May 3, 1961, Milwaukee, Wisconsin.

Doctor Roth is Professor of Clinical Gastroenterology, and Director of the Division of Gastroenterology, Graduate School of Medicine, University of Pennsylvania.

Effects of Operative Procedures on Mechanisms of Hydrochloric Acid

SECRETION AND MOTILITY

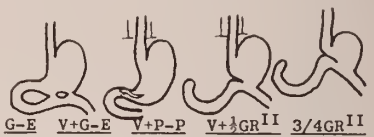
The various operative procedures used in the therapy of peptic ulcer not only differ in what they achieve in relation to eliminating the mechanisms of hydrochloric acid secretion but also differ in their predisposition to the various pathophysiologic side effects, depending upon what segment and amount of stomach is resected, the type of anastomosis (gastroduodenal or gastrojejunal), and whether it has been combined with vagotomy. Table 1 summarizes the physiological effects of various operative procedures upon the mechanisms of hydrochloric acid secretion and motility.

A *simple gastroenterostomy* permits partial neutralization of gastric acid by enterogastric regurgitation of alkaline duodenal content through the stoma, but this benefit may be offset by interference with acid inhibition of gastrin release, resulting in a net increase in acid secretion. If the gastroenterostomy effectively drains the stomach, it reduces motor activity in the pyloroduodenal area of ulceration. Drainage of the gastric content through the stoma also tends to reduce the "jet stream" effect and divert acid away from the ulcer-bearing area to facilitate healing. However, the secretory capacity of the parietal cell mass of the stomach has not been reduced in the absence of a resection of the body of the stomach, and with the antrum intact the gastrin mechanism continues to function. Unless a vagotomy is combined with the gastroenterostomy, there is no reduction in vagal influences.

The *addition of vagotomy to gastroenterostomy* considerably reduces motor activity as well as eliminates the vagal mechanism and its potentiating influence upon the gastrin mechanism. By withdrawing tonic vagal activity, vagotomy also depresses the responsiveness of the parietal cell mass to all stimuli.

Vagotomy and pyloroplasty permits more than the usual amount of reflux from the duodenum into the stomach for partial neutralization, but again an alkaline pH in the antrum may interfere with acid inhibition of gastrin release. Motor activity at the pyloroduodenal junction is slightly less reduced than with a gastroenterostomy combined with vagotomy because there is no stoma diverting gastric acid away from the ulcer-bearing area. A patulous pyloroplasty further reduces the "jet stream" factor in the pathogenesis of peptic ulceration. Again, in the absence of a resection, the parietal cell mass has not been reduced and the presence of the antrum releases gastrin to stimulate the parietal cells. However, the vagotomy eliminates vagal influences and suppresses the responsiveness of the parietal cells to all other stimuli, abolishes gastrin release by vagal stimulation, and reduces the responsiveness of the pyloric glands to local stimuli for release of gastrin.

TABLE 1—*Effects of operative procedures on HCl secretion and motility*



	G-E	V+G-E	V+P-P	V+⅓GR[II]	3/4GR[II]
NEUTRALIZATION	+++[a]	+++[a]	+[a]	++++	++++
PARIETAL CELLS ↓	-	(-)	(-)	+++	++++
VAGAL INFLUENCES ↓	-	++++	++++	++++	(-)
GASTRIN ↓	-	(-)	(-)	++++	++++
DIVERSION OF HCL	++	++	-	++++	++++
JET STREAM ↓	+	++	+++	++++	++++
MOTILITY ↓	+	+++	++	++++	+++

a = interferes with acid inhibition of gastrin release
(—) = effect qualified by vagal influences

The physiologic advantages of *vagotomy and 50% gastric resection* in reducing the acid secretory capacity of the stomach are apparent in Table 1. Reflux neutralization through a Billroth II anastomosis is more of an advantage in the absence of the antrum. The Billroth II procedure also reduces motor activity and diverts acid away from the ulcer-bearing area which has been resected. A 50% resection, however, does not reduce the number of parietal cells in the stomach remnant as effectively as a more extensive resection, and for that reason may be an inadequate resection if the complementary vagotomy proves to be incomplete.

Complete vagotomy eliminates the vagal influences and the distal 50% resection removes the antrum and gastrin mechanism. A *three-quarter subtotal gastric resection* permits reflux neutralization, reduces motor activity and diverts acid away from the ulcer-bearing area, effectively reduces the number of parietal cells in the stomach remnant, and eliminates the gastrin mechanism.

TABLE 2—*Undesirable side effects of operative procedures*

	G-E	V+G-E	V+P-P	V+½GR^{II}	3/4GR^{II}
DUMPING	+	+	+	+++	++++
MALNUTRITION	±	+	±	+++	++++
GASTRIC STASIS	-	++	+++	±	-
DIARRHEA	±	+++	++	+++	++
ANAST. ULCER	30%	8%	12%	0.5-5%	2-3%
MORTALITY	0.5%	1-2%	1-2%	1.4-2.7%	2-3%

In the absence of a complementary vagotomy, there is less reduction of motor activity and the vagus mechanism itself is intact. However, because of the synergistic interrelationship of these mechanisms, removal of the gastrin mechanism with antrectomy reduces the responsiveness of the parietal cells to vagal stimuli, indicated by the qualified negative designation in Table 1. The obvious overwhelming superiority of vagotomy with a three-quarter gastric resection in reducing gastric secretion and motility are unfortunately dampened by the disadvantage of an increased incidence of undesirable side effects.

UNDESIRABLE SIDE EFFECTS OF OPERATIVE PROCEDURES

The more extensive resection, which usually necessitates a Billroth II anastomosis, is more likely to give rise to the *dumping syndrome,* and especially if it is done in a nervous woman. Although the dumping syndrome may occur with any of these operative procedures (Table 2) and even in the unoperated individual with autonomic instability, a larger stomach reservoir with a pyloroplasty or gastroenterostomy may be associated with a slightly lower incidence of dumping sensations. Maintenance of gastroduodenal continuity with these procedures favors *postoperative nutrition* by permitting optimum stimulation of external pancreatic secretion and mixing of food particles with the bile and pancreatic juice for more efficient digestion and absorption as the chyme passes down the small intestine. Whereas, the gastrojejunal anastomosis bypasses the outflow of these important digestive juices, and thus the food does not adequately mix with them as it passes rapidly down into the terminal ileum. This poor coordination between gastric emptying and the outflow of bile and pancreatic juice contributes to postgastrectomy malnutrition, although a reduction in food intake is the most important factor responsible for this malnutrition. Thus, the disadvantages of the three-quarter gastric resection are indicated by the higher incidence of the dumping syndrome and postgastrectomy malnutrition.

Although these side effects are considerably less frequently encountered with pyloroplasty or gastroenterostomy and vagotomy, the latter procedures have a higher incidence of *diarrhea and gastric retention,* with or without stasis ulceration. The chief disadvantage of these two procedures lies in the relatively high incidence of anastomotic ulcer recurrence.

The nationwide survey of the American Gastroenterological Association several years ago showed an incidence of at least 15% *recurrent ulcers* after gastroenterostomy alone. This figure is closer to 30% in follow-up evaluations of longer duration. When vagotomy was combined with gastroenterostomy, the five-year follow-up studies of both Crile and Dragstedt have shown an anastomotic ulcer incidence of 8%.

Insufficient time has elapsed since the introduction of pyloroplasty combined with vagotomy to give an absolute figure. However, Stempien working with Weinberg has reported to me that 5% of their patients have developed duodenal ulcer and an additional 7% have developed ulcer symptoms without x-ray proof of the ulceration in a five-year follow-up at Long Beach, California. The relatively high incidence of anastomotic ulcer following gastroenterostomy or pyloroplasty with complementary vagotomy is due to the incompleteness of vagotomy in as high as 30 to 40% of the patients.

I would predict that recurrent ulceration might occur in approximately 5% of patients having a 50% resection and vagotomy because many patients with an incomplete vagotomy will have an inadequate gastric resection, depending upon their preoperative acid capacity. However, Scott has reported an incidence of anastomotic ulcer of only 0.5% in a five-year follow-up of at least 50% of the patients subjected to vagotomy with antral resection.

The general experience throughout the country is that approximately 2 to 3% of patients with a three-quarter gastric resection will have anastomotic ulcer, and this incidence might be further reduced by having

a complementary vagotomy performed in *selected patients* with extremely high preoperative acid capacity. Less extensive resections cause fewer side effects but also lead to a higher rate of recurrence. Thus, an inverse relationship exists between the reduction of free acid secretion by these various operative procedures and the subsequent recurrence of ulceration. Unfortunately, the more effective the procedure is in reducing acid secretion, the greater the incidence of pathophysiologic side effects.

Considerations in Individualized Choice of Ulcer Operation

Continued experience with the results of these various operative procedures has appeared to justify their *selection on an individualized basis*—using that operation most necessary to prevent ulcer recurrence, when that objective takes priority over the risk of undesirable side effects; or, selecting a procedure less likely to give rise to malnutrition or dumping when circumstances permit a compromise on the risk of ulcer recurrence. We no longer think in general terms of what is the best operation, but what is the *most appropriate operation* for this individual patient under the existing circumstances.

Our individualized choice of operation takes into consideration a number of factors: (1) the risk of the operative procedure in terms of mortality and morbidity, which in part depend upon the experience of the surgeon, (2) the magnitude of preoperative free acid capacity, (3) the nervous temperament as it predisposes to "dumping" sensations, (4) the nutritional state and preoperative weight as it predisposes to postoperative malnutrition, (5) the location of the ulcer, and (6) the surgical anatomy or pathology of the ulcer encountered at the operating table. The surgical pathology may dictate the type of operative procedure the surgeon will have to perform, despite his preferential preoperative consideration of the various factors involved.

Individualized Selection of Operative Procedure

Without attempting to define the complete set of circumstances, I would like to illustrate this concept of *individualized selection of operative procedure*. If the patient is elderly, a poor operative risk, possibly obstructed but not hemorrhaging, and has a low peak free acid capacity (25 to 40 clinical units with the Ewald test meal), a *gastroenterostomy alone* may suffice to bypass the obstruction and prevent ulcer recurrence by simply facilitating neutralization of the low acid titer through enterogastric regurgitation. However, if the acid capacity were moderately high (50 to 75 clinical units) and the patient of a very nervous temperament, a vagotomy might be added to the gastroenterostomy to abolish the vagal mechanism but still retain the reservoir of the stomach with less likelihood of dumping.

Gastroenterostomy plus complementary vagotomy might be the choice with a large inflammatory mass about the ulcer, which might make the duodenum difficult or impossible to mobilize. It might be unwise to attempt resection with removal of the ulcer because of its location or confined perforation into the pancreas or bile ducts; or, if the patient is so obese that closure of the duodenal stump would be difficult, it might be safer to perform a gastroenterostomy and vagotomy. However, if circumstances otherwise permitted, a gastroenterostomy plus complementary vagotomy would not be the procedure of choice when the free acid capacity exceeded 100 clinical units. If the vagotomy proved to be incomplete, this patient would be left with only a gastroenterostomy and almost certain development of marginal ulceration with such a high acid titer.

A *pyloroplasty with vagotomy* might be desirable and adequate for the nervous patient with moderate acidity, and especially if he is thin and maintenance of gastroduodenal continuity would be advantageous for postoperative nutrition. However, the operation of pyloroplasty and vagotomy would not bypass cicatricial obstructing stenosis, or a large inflammatory mass might not permit the surgeon to do a pyloroplasty, nor would this procedure arrest a hemorrhage. The addition of direct "ligature exclusion" of the crater might stop bleeding.

A *50% distal gastric resection plus vagotomy* would correct the pathologic condition of duodenal stenosis or hemorrhage and still be adequate in the patient with moderate acidity (50 to 85 clinical units) by also eliminating the gastrin mechanism through antrectomy. The less extensive resection is usually adequate for the benign ulcer located in the stomach, and perhaps would be less likely to give rise to dumping in the nervous wo-

man by leaving a larger reservoir. This procedure may be used for the most frequent cause of medical intractability; namely, the densely adherent posterior penetrating ulcer with confined perforation, as well as for the ulcer postbulbar in location. If the vagotomy proves to be incomplete, however, it is very likely that a 50% resection would be inadequate for those patients whose preoperative free acid capacity exceeded 100 clinical units. In patients who are very thin and in whom it may be difficult after extensive resection to maintain nutrition, we are prepared to risk ulcer recurrence after vagotomy and 50% gastrectomy, rather than subject the patient to a more extensive resection with its attendant danger of intractable nutritional disturbances.

If the patient is thin, a nervous woman, and the ulcer bed not adherent to the pancreas or surrounded by dense scar tissue, gastroduodenal continuity with a Billroth I anastomosis might then be preferred and technically possible with the less extensive resection. Such a procedure would be less likely to give rise to the dumping sensations and would favor maintenance of nutrition. A distal hemigastrectomy with the Billroth I anastomosis would be adequate for many benign gastric ulcers, but this procedure would not be applicable if the ulcer could not be excised safely, or if it were postbulbar in location with stenosis. Unfortunately, gastric stasis may follow this anastomosis and require re-operation, particularly if a complementary vagotomy has been performed.

In the majority of patients, that is, the usual case that we refer for surgery, there is a grade III hyperacidity (greater than 75 to 100 clinical units), and the ulcer bed is adherent with confined perforation, or operation is indicated by stenosis or hemorrhage. Under these circumstances, it is necessary to do a three-quarter gastric resection with Billroth II anastomosis. The Billroth I procedure is technically not possible as a rule because of adherence to surrounding structures, and because a more extensive resection is necessary to reduce the acid capacity. A 50% resection would be inadequate with this acid capacity, even though combined with a vagotomy in those patients where the vagotomy eventually proved to be incomplete. We have recently had this experience with development of anastomotic ulcer and melena. However, if the patient is reactive and nervous or thin, we would avoid this extensive resection whenever the circumstances of surgical pathology or acid capacity justify a compromise. If the ulcer is adherent by confined perforation to the pancreas, and resection is necessitated by distal bulbar cicatricial stenosis, a Bancroft exclusion procedure with stripping of the antral mucosa and closure of the stump through the cuff of antrum might be safer than attempting to dig the ulcer crater off its attachment. The slightly increased risk of ulcer recurrence with the exclusion procedure is justified rather than taking the chance with an operative mortality or traumatic pancreatitis, pseudocyst or pancreatic abscess. However, if the free acid capacity exceeds 100 to 125 clinical units, the procedure of choice at the outset might be a three-quarter resection plus complementary vagotomy in order to insure the greatest likelihood of adequate reduction of free acid capacity. The risk of ulcer recurrence in this individual may take priority over the chance of undesirable side effects.

If the patient develops *an anastomotic ulcer* which fails to respond to the usual strict "stomach rest" regimen, or recurs prematurely, further therapeutic considerations will depend upon the initial operative procedure that has already been performed. After a gastroenterostomy alone, a distal resection of 50 to 75% of the stomach, with or without complementary vagotomy should be considered, depending upon the level of free acid in the stomach. If vagotomy and gastroenterostomy or pyloroplasty have previously been performed, an insulin gastric analysis should be performed to evaluate vagal continuity. If the free acid response to insulin hypoglycemia demonstrates the persistence of the vagal mechanism, the surgeon should make another attempt to completely sever the vagus innervation by looking for an intramural or other anomalous branch of the vagus. However, a distal resection of 50 to 75% of the stomach should also be performed at that time. If anastomotic ulcer develops after a 50% resection and vagotomy, vagal continuity should be evaluated, and the additional vagal fibers severed if their persistence is demonstrated by the insulin test. When the patient is re-operated, however, further resection of the body of the stomach should be undertaken to leave approximately one quarter of the original stomach, and the duodenal stump inspected for retained antrum, as well as the pancreas explored for

possible adenomas. If the patient has already had a three-quarter gastric resection, the surgeon should inspect the duodenal stump for retained cuff of antrum which permits the gastrin mechanism to maintain acid secretion, and he should also explore the pancreas for possible ulcerogenic adenomas, as well as perform a bilateral complete vagotomy. Management of the patient who develops anastomotic ulcer after a three-quarter gastric resection and vagotomy requires more desperate considerations. Re-operation may not be feasible because of the operative risk at this time, and consideration may have to be given to x-ray therapy as recommended by Walter Palmer to temporarily suppress the residual acid capacity and tide the patient over the ulcer recurrence. Vagal continuity should, of course, be evaluated before the patient is again operated, and the duodenal stump inspected for retained cuff of antrum. The latter may maintain a high free acid capacity in the stomach remnant after two-thirds or three-quarter gastric resection. I have had the experience where the surgeon removed more of the stomach remnant at his second operation and failed to remove a liberal cuff of antrum, which was found at a subsequent operation when the patient still secreted 56 units of free acid. Partial pancreatectomy including the body and tail may be necessary in those patients who develop anastomotic ulcer after a three-quarter gastric resection with proven complete vagotomy and who continue to maintain a grade III or IV hyperacidity. Partial pancreatectomy may be justified even though the surgeon is unable to see or palpate an ulcerogenic adenoma which is proven to exist under microscopic section. However, if despite these measures ulcer recurs, or if the Zollinger-Ellison syndrome is recognized, nothing short of total gastrectomy will cure the patient of his intractable ulcer diathesis.

Conclusions

In our experience, the occurrence, severity, and persistence of gastric stasis after vagotomy combined with gastroenterostomy, pyloroplasty, or the Billroth I resection has been so troublesome that these operations are currently employed relatively infrequently. They are reserved for those patients where over-riding priority is given to the need for preserving the gastric reservoir, and maintaining gastroduodenal continuity in the extremely thin and nervously reactive individual; or, when an inflammatory mass or confined perforation does not permit safe resection at the time. Depending upon the free acid capacity, hemigastrectomy with the Billroth II anastomosis and vagotomy, or three-quarter gastric resection are the procedures employed for the majority of our patients with intractable or complicated duodenal ulcer disease. Distal 50% gastrectomy and vagotomy is challenging the place of three-quarter subtotal gastrectomy in this surgical management. Thus, by selecting the operation to fit the problem of the individual patient, it is hoped that the incidence of postoperative pathophysiologic disturbances will be reduced.

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STAPHYLOCOCCI GERMS IN HOSPITALS STUDIED

With the rise of staphylococci germs in hospitals that are largely resistant to drugs, many hospitals have adopted new aseptic controls for nurses and doctors who may be carrying the microbes and possibly infecting patients.

A team of Boston surgeons reported recently on the relationship between operating room personnel who are "staph" carriers and the amount of infection resulting in the wounds of surgical patients.

They concluded that "carriers of the staphylococcus among operating room personnel are frequent but the development of wound infection caused by carrier strains is infrequent."

A total of 139 operations in which carriers were present was studied. In only nine of these did infections occur and in only two of the nine was the infection traceable to a carrier. In the other seven, the source could not be found.

There was no relationship found between the infections and cultures taken from the air, bed clothing or other environmental sources.

The authors concluded that the source itself is but one factor in determining whether a patient will have a wound infection. Other factors, they believe, are the resistance of the patient himself and the virulence of the germ.

The report was presented to the 47th annual Clinical Congress of the American College of Surgeons, Oct. 2–6, by David D. B. Woo, M.D., Thomas F. Silva, Jr., M.D., Alice T. Marston, Ph.D., and Chester W. Howe, M.D., F.A.C.S.

Incidence of Beta Hemolytic Streptococcus

By CHARLES K. KINCAID, M. D., M. S. P. H.; EVELYN C. NELSON, R. N., B. S.; and THAYER W. BURNHAM, M. S.

Madison, Wisconsin

A THREE-YEAR study* of the incidence of beta hemolytic streptococcus was completed in July, 1960, in the Department of Public Health, Madison, Wisconsin. This is a report of the structure and findings of the study.

The investigation was undertaken because of the paucity of data concerning the occurrence of this organism in public school children in an "open" population in a northern city in this country.

Studies on "closed" populations (service personnel) have been reported with helpful thoroughness for many years, at least as far back as Schwentker's report[1] in a naval training station in 1943 and by the 1945 report[2] of the Commission on Acute Respiratory Disease, Fort Bragg, N. C. Pretorius[3] reported preliminary findings of 8.6% incidence in a community study begun in February, 1959, in North Dakota. Quinn[4] found in Nashville, Tennessee, "unusually high" carrier rates from 26% to 60% in three different schools. Saslaw[5] reports 20.1% of children studied in Miami, Florida, had the organisms present at least once in a 1954 study. In Philadelphia, Cornfeld[6] found an incidence of 28% in the peak month. During a scarlet fever epidemic in Milwaukee, Wisconsin, in 1935, Koehler[7] found that 24% of 25,000 children had the organism present.

The study was undertaken to answer questions raised by practicing physicians carrying out our community control program begun in May 1951:

1. Is every child likely to have the organism present some time during the year?
2. Is the organism present in some throats most of the time?
3. Is the organism frequently present without any associated signs or symptoms?
4. Is the organism present in most children's throats at peak periods of the year? And
5. Is Group A commonly present?

The continuing importance of the Group A beta hemolytic organism is attested by Waisbren's[9] inclusion of this organism in his list of 15 bacteria which cause the majority of infections seen in this country.

Although rheumatic fever, an occasional sequela of infection by the Group A organism, has been reported to be on the decline, the reliability of such reports is open to question. In Minnesota, Rosenfield[10] found that physicians were *treating* 2,600 cases of rheumatic fever in 1955. In the previous five-year period the average number of cases *reported* was only 187 per year. In 1952, rheumatic heart disease was found in 2.2% of seventh grade Madison children by Quinn.[11] Other occasional sequelae include glomerulonephritis and otitis media. The importance of infection by this organism thus appears to the authors to be sufficient to justify the past studies, the current ones and expansion of jointly planned community control programs.

Description of Study

This study was conducted in the years 1957–1960, in Madison, Wisconsin, a city with a population of 125,000 located in south central Wisconsin. The mean annual temperature during the study years was 45.7, 45.7, and 44.8 F. Permission for the study was readily granted by school administrators and parents of the study children.

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Doctor Kincaid is Health Commissioner, City of Madison.

TABLE 1—*Schools and Number of Children in Study*

Year	Sherman	Washington	Dudgeon	Total
1957–1958	132	142	129	403
1958–1959	145	132	134	411
1959–1960	127	136	139	402

TABLE 2—*Absenteeism and Cultures Collected on Home Call*

	Absentees	Cultured	Positive	Negative	Pos. with URI	Neg. with URI
1957–1958	279	262	38	224	30	114
1958–1959	305	290	78	207	55	114
1959–1960	303	287	54	233	36	140
Total	887	839	170	664	121	368

(URI—for definition refer to footnote Table 8).

Four hundred children (plus a few extra to assure reaching at least 400) in three different schools (Table 1) in Madison, located east, west and centrally, had throat cultures twice a month beginning in early winter (December) and ending when school closed in June. This schedule was repeated unchanged for each of three years. Socio-economic differences among Madison schools are not marked so were deemed of less significance than geographic location in developing a satisfactory sample. Absentees (Table 2) in the test group were "cultured" by making a home visit. Symptoms were recorded and reasons for absence in order to find out whether including the absentee child would significantly alter the study findings. The ratio of positive to negative cultures obtained from the absentees (Table 2) was such that when included in the total group they did not appreciably alter the findings. Among absentees with upper respiratory illness, 121 had positive cultures while 368 had negative cultures. The test group was composed of fourth graders in the three schools plus enough from grades three and five to fill out the group. Eighty-five per cent of fourth graders in these three schools were enrolled in the study group each of the three years.

Throat swabs were taken starting at 9:45 a.m. by a registered nurse, and placed in a dry sterile tube. When about 65 specimens were obtained, they were transported by auto to our laboratory where they were immediately processed. In no case was there a greater lapse of time than two hours between taking the swab and inoculation of the blood agar plates. On the first three days of a week, one day to each school, specimens were collected from one-half the study population in each school. Wherever possible, cultures were taken from whole school rooms at a time. On the first three days of the following week, one day to each school, specimens were collected from the other half of the study population.

1. The swabs were streaked directly on Difco neopeptone infusion agar enriched with 5% defibrinated sheep's blood. To facilitate the identification of low oxygen tension organisms the surface of the streaked agar was cut in several places with a loop or needle.
2. All plates were incubated at 37 C. for approximately 24 hours and read for the presence of beta hemolysis. Hemolytic and suspicious colonies were selected and subcultured on the same type of blood agar medium and again incubated for 24 hours at 37 C.
3. Typical beta hemolytic streptococci colonies from Step 2 were selected and used to prepare broth cultures from which extracts were obtained for grouping.
4. The capillary tube modification of the Lancefield hot hydrochloric acid method was used to group all of the beta hemolytic streptococci cultures isolated.

Parents and family physicians were notified if a child had a positive culture. If a child was sick, we recommended seeing the family physician. Some of these children were then treated and presumably this prevented some secondary cases. It was realized that this would interfere with the final outcome of the study so the decision was taken advisedly. When study children were treated with an antibiotic for any reason, no swabs for culture were taken until 24 hours had passed after the final treatment.

Results

Figure 1 shows the three years of the study, by years and by percentage of children positive at any one time. Percentages in Figure 1 are listed in Table 3.

The highest percentage of children having positive throat cultures for beta hemolytic streptococcus was 30.2%. This expresses the highest number of children having the organism present at any one time. Figure 1

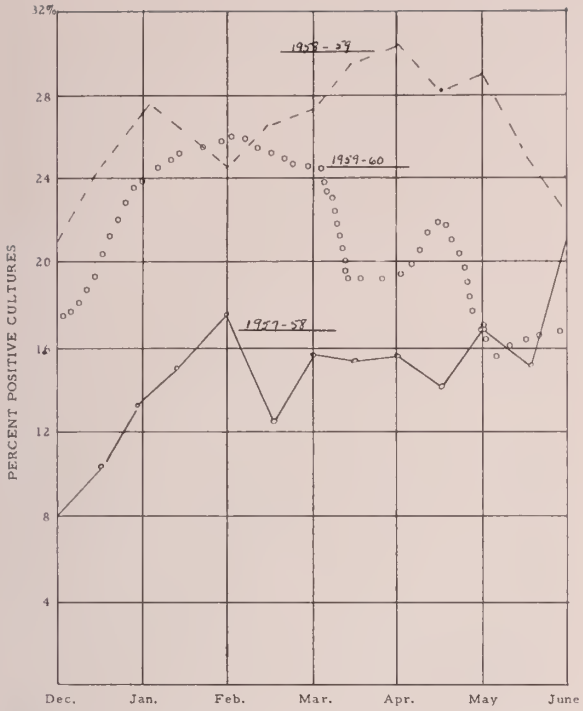

Fig. 1—Percentage of children with positive throat cultures.

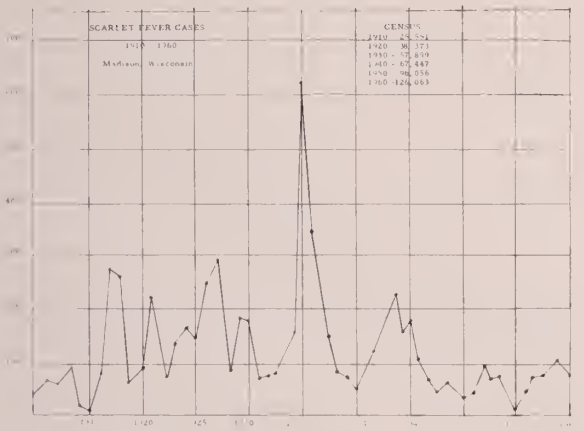

Fig. 2—Scarlet fever cases, 1910–1960, Madison, Wisconsin.

shows this occurred in April, 1959. In the first study year the highest point was reached in June at 21.2%. In the last study year the highest point was 25.8% and occurred in February.

One wonders if this period of time (December, 1957, to June, 1960) encompassed the widest swings to be expected. Such is indeed questionable if one recalls widespread epidemics of the past due to this organism. During these years, the only control devices available were the rather ineffective methods of isolation and quarantine. (Fig. 2)

TABLE 3—*Percentage of Children with Positive Cultures, Semi-Monthly*

	1957–1958	1958–1959	1959–1960
Dec. 1st half	7.9%	20.3%	17.4%
Dec. 2nd half	10.1	25.1	19.8
Jan. 1st half	13.2	26.9	22.9
Jan. 2nd half	14.8	25.8	23.6
Feb. 1st half	17.7	24.3	25.3
Feb. 2nd half	12.4	25.9	25.8
Mar. 1st half	15.7	26.9	24.7
Mar. 2nd half	15.4	29.4	19.3
Apr. 1st half	15.5	30.2	18.8
Apr. 2nd half	14.3	28.0	22.1
May 1st half	16.7	29.5	15.6
May 2nd half	15.3	25.4	16.4
June 1st half	21.2	23.1	16.8

Figure 2 shows 50 years of reported cases of scarlet fever in Madison and is included to suggest the year-to-year variation in a streptococcal disease.

Incidence of streptococcal pharyngitis plus scarlet fever as reported to the health department office during the period of the study is seen in Table 4. Also in this table are figures showing the total percentage of cultures which were positive in our study population in each of the three study-year periods.

TABLE 4—*Incidence of Streptococcal Pharyngitis plus Scarlet Fever*

Study-Year Period	Reported Cases Among All Madison Children	Percentage of Cultures Positive in the Study Population
December 1957 to June 1958	364	15%
December 1958 to June 1959	647	26%
December 1959 to June 1960	364	20%

The correlation is not as high as might have been expected.

Table 5 is included for purposes of comparison with reports of similar studies. It shows that 30% somehow escaped ever having the organism present at the two-week culture date through the study years.

TABLE 5—*Cumulative Percentages of Students Positive at Least Once*

Month	1957–58	1958–59	1959–60
December	11.90	24.29	22.1
January	26.90	38.69	38.1
February	34.07	47.30	44.5
March	39.81	58.34	51.1
April	45.34	67.04	54.8
May	51.14	69.44	58.7
June	54.73	69.44	60.2

In Table 6 showing the frequency of identification of Groups, it is seen that Group A consistently is the most common and that Group G is the next. In third place we found

TABLE 6—*Frequency of Identification of Groups*

Year	1 Tot. Cult. Done	2 Cult. Pos.	3 A	4 B	5 C	6 D	7 E	8 F	9 G	10 NG	11 Tot. Grpg.	12 NI
1957–1958	5,029	744	412	57	49	0	0	24	151	33	726	18
1958–1959	5,136	1,349	1,038	49	44	0	0	75	130	25	1,361	2
1959–1960	5,203	1,084	750	31	83	0	0	68	111	47	1,090	0

Notes: a. The difference in column 2 and column 11 is because from some plates more than one group was isolated and some cultures were lost for grouping.
b. Group D is an enterococci which seldom hemolyzes sheep's blood.
c. Group E were not found.
d. NG Beta Hemolytic streptococci not grouping in sera A through G.
e. NI Beta Hemolytic streptococci isolated but lost for grouping.

Group B the first year, Group F the second year and Group C the third year. Groups A, C, and G are the most frequent causes of streptococcal disease in man[12] with Group A strains comprising by far the majority. Other Groups are sometimes pathogenic but usually as secondary invaders.[12]

When the percentage of Group A of all cultures collected is calculated (Table 7), it is seen that in the study years when an increase in cultures positive for beta hemolysis occurred it was due to an increase in the Group A strains. Groups other than "A" remained at or near 6% in each year.

TABLE 7—*Total Cultures and Percentage of Group A As Compared to All Other Groups*

Year	Total Cultures	Cultures Positive	Percent All Cultures Group A	Percent All Cultures Groups other than A
1957–58	5029	744	8.2	6.6
1958–59	5136	1349	26.2	6.0
1959–60	5203	1084	20.8	6.4

TABLE 8—*Correlation of Symptoms with Streptococcus Group In Children With Positive Throat Cultures 1958–59 & 1959–60*

1958–1959				1959–1960			
Group	Mild Symptoms	Severe Symptoms	No Symptoms	Group	Mild Symptoms	Severe Symptoms	No Symptoms
A	961	35	41	A	622	14	114
B	46	0	3	B	19	-------	12
C	41	0	2	C	65	-------	18
D	0	0	0	D	0	-------	0
E	0	0	0	E	0	-------	0
F	70	0	5	F	55	-------	13
G	124	1	5	G	89	-------	22
NG	21	0	4	NG	42	-------	4
NI	1	0	1				
Total	1264	36	61		892	14	183

"Mild Symptoms" were symptoms of URI including inflammation of throat, one degree or less fever, sometimes cervical adenitis.
"Severe Symptoms" were symptoms of URI, over one degree fever, usually cervical adenitis and toxemia.
"No Symptoms" were absence of these symptoms except some had slight pharyngitis not thought significant.
1958–1959. An A and a C had no follow-up for symptoms and are not included in the above table.
1959–1960. An NG had no follow-up for symptoms and is not included in the above table.

Clinical Observations

During the three study years, every child with a positive culture was queried and inspected in an effort to determine the presence or absence of illness possibly caused by the streptococcus in the throat. Parents were queried as well as physicians when the child had seen one. They were then categorized as having no symptoms, mild symptoms, or severe symptoms. Identifying the "group" of the streptococcus present, and the "grade" of symptoms is reported in Table 8. Findings of the first year are omitted as it was discovered that inquiry about symptoms was delayed due to lack of staff, often as late as five days after the culture was taken.

Firm conclusions should not be drawn from this table for at least three reasons: (1) A similar study of symptoms of pharyngitis among study children with negative cultures was not possible and was not done; (2) the recorded symptoms may have been due to some other cause; and (3) grading the severity of symptoms is a highly variable thing even among well-trained observers.

However, it is of interest to note that a positive culture was much more frequently associated with some symptoms than with none and that Group A almost always seemed to be the cause of severe symptoms. About 10% (244) had no symptoms or signs on the day after collection of a throat culture that was found to be positive.

Comparing the number of cultures positive for Group A before treatment (penicillin intramuscularly or 10-day oral, only) among those study children treated during the two years with the number of cultures positive for Group A after treatment is seen in Table 9. The percentage of cultures found positive on the same children after treatment was 4.5%; the percentage positive before treatment was 43%.

TABLE 9—*Cultures Positive for Group A Before and After Penicillin*

Before Treatment			After Treatment		
	Negative	Positive		Negative	Positive
1958–59	157	87	1958–59	247	21
1959–60	194	178	1959–60	281	4
	351	265 (43%)		528	25 (4.5%)

Table 9 is offered in support of the well established opinion that adequate penicillin therapy is effective against this organism. The study of effects of other types of therapy was considered beyond the scope of this report.

A possible relationship of the presence of tonsils may be postulated from Table 10 in which positive Group A cultures occurred 46% of the time when tonsils were present, but 28% of the time when tonsils were absent. None of the cultures in this table were from children who had penicillin treatment. Tonsils reported as absent were absent before the study began or removed during the study.

TABLE 10—*Cultures Positive for Group A and Presence of Tonsils*

	Tonsils Present		Tonsils Absent	
	Negative	Positive	Negative	Positive
1958–59	640	580	464	190
1959–60	469	397	262	106
	1109	977 (46%)	726	296 (28%)

Satisfactory statistics comparing symptoms and negative or positive culture status would require examination by physicians of all 400 children twice a month; this was considered to be far too expensive for this project. Children who had positive cultures, however, did arouse our concern and were therefore checked. Having this observation on hand it is offered for consideration. Of particular interest were those children who had the organisms present most of the time. Table 11 shows just a few of these, taken from the last year of the study and represents an extreme. About the only conclusion which can be made is that the Group A organism may be present almost continuously in an occasional child without causing severe symptoms. In forming a clinical decision about cases of this sort, as to whether the organism is living an almost saprophytic existence or causing a chronic low-grade infection, it would seem necessary to obtain further information before withholding treatment. Experimental proof of the virulence or nonvirulence of a particular Group A organism cultured repeatedly from a child such as one of those in Table 11 would be helpful. Repeated measurement of the concentration (rising or falling) of antistreptolysin O or antistreptokinase would also help decide whether or not the patient was "affected." This is not commonly done in the usual clinical situation. Thus, the importance of a careful history again appears as a sine qua non for proper management of the mild case of streptococcal pharyngitis.

Summary

Four hundred children in three Madison, Wisconsin, schools, most in grade four, had

TABLE 11—*Students Positive Most of Time, 1959–60, December to June, Grouping and Symptoms*

Child Number	Culture Findings, Group and Symptoms												
5	–	(A)	(A)	(A)	(A)	(A)	(A)	(A)	---	A	A	A	(A)
324	A	[A]	A	(A)	(A)	(A)	(A)	---	(A)	(A)	---	(A)	(A)
469	(A)	(A)	---	(A)	(A)	(A)	(A)	(A)	(A)	(A)*	---	(A)	(A)
477	---	(A)	(A)	(A)	A	(A)	(A)	(A)	(A)	(A)	---	G	A
601	---	---	(A)	(A)	(A)	(A)	(A)	(A)	A	(A)	(A)	(A)	(A)
767	---	---	(G)	(G)	(G)	(G)	G	G	(G)	(G)	(G)	G	G
775	(G)	(G)	---	(G)	(G)	(G)	(G)	---	[A]*	(G)	(G)	(G)	(G)
779	(A)	(A)	(A)	---	(A)	(A)	(A)	(A)	A	---	(F)	(A)	A
16	---	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	A	(A)	A	(A)
25	(G)	(G)	G	(G)	(G)	(G)	(G)	(G)	---	(G)	G	G	(G)
177	(A)	(A)	(A)	A	A	A	---	(A)	(A)	A	(A)	A	A
650	C	(C)	(C)	(C)	C	C	(C)	(C)	(C)	(C)	---	(C)	(C)
660	---	(A)	(A)	A	A	(A)	(A)	(A)	(A)	(A)	(A)	A	(A)
797	(A)	(A)	(A)	(A)	(A)	(A)	---	(A)	(A)	(A)	(A)	A	(A)
815	(G)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(G)	(A)	---	(A)	(A)
176	(NG)	(NG)	(NG)	(F)	(A)	(G)	(F)	(G)	(NG)	(NG)	(G)	(NG)	(G)
356	(A)	(A)	(A)	(A)	(A)	(A)	A	(A)	(A)	(A)	(A)	(A)	(A)
754	(C)	C	C	(C)	(C)	(C)	C	(C)	(C)*	(C)	(C)	(C)	(C)
770	(A)	(A)	(A)	(A)	A	G	(G)	(A)	G*	(G)	(G)	(G)	G

( ) Mild symptoms.
[ ] Severe symptoms.
* Treatment with penicillin intramuscularly or 10 days oral penicillin.

throat swabs taken twice a month, December to June, for three years. The highest percentage of swabs positive for beta hemolytic streptococcus at any one time was 30.2%, in April of the second study year. All absentees received a home visit to collect throat swabs and an illness history. All positive cultures were grouped. In addition to confirming the previously reported preponderance of Group A, we observed that when the incidence of infection increased it was due to an increase in this one Group. However, it was observed that a positive culture was more frequently associated with suggestive symptoms than with none; and that among those with symptoms, the Group A was by far the most common. When symptoms were more severe, Group A was present 50 times to a single occurrence with a different Group. Study of cultures made on children who had received penicillin therapy showed that all but a few were "cleaned up." In dividing the study group according to presence or absence of tonsils, it was observed that a difference evidently did exist, in that the presence of tonsils seemed to nearly double the frequency of finding a positive culture.

And finally, it became obvious that the Group A hemolytic streptococcus can exist in the throats of a few children almost continuously without obvious symptoms, perhaps living as a nonvirulent saprophyte. Whether such organisms ever regain their virulence for other children was not investigated. It is suggested that this finding ought not jeopardize the proper therapeutic management of the usual case, even though the history and the signs and symptoms indicate a mild infection.

Room 507, City-County Building.

ACKNOWLEDGMENT: The authors here express their gratitude to the many persons who made this study possible by their guidance, sanction and personal contribution of time and trouble. These include the Board of Health, Mayor Ivan Nestingen, the City Council, the Auditor, the Personnel Agent, the Purchasing Agent, Dr. A. S. Evans and Dr. C. V. Seastone of the University of Wisconsin, Dr. Robert Quinn, University of Tennessee, school administrators and teachers, parents of and the children in the study group and many others in medicine and in public health whose support and interest was of great encouragement.

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OBSTETRICAL BRIEF

From the Division on Maternal and Child Welfare of the State Medical Society of Wisconsin

Recently a new product Syntocinon nasal spray has been introduced into the field of obstetrics for the specific function of aiding milk let-down. It is only natural that inquisitive physicians should use this drug for the induction and stimulation of labor. Since Syntocinon nasal spray does not allow the physician to carefully control the dose administered, it should not be used ante partum or intra partum. Dilute intravenous Pitocin drip is still the method of choice for use before or during labor. Experience has proven the safety of this method of administration. With this in mind it would be wise to heed the packaged literature enclosed by the manufacturer of Syntocinon nasal spray which says "THE USE OF SYNTOCINON NASAL SPRAY INTRA PARTUM IS NOT RECOMMENDED."

The Use of an Aldosterone Antagonist in Refractory Congestive Heart Failure

By WILLIAM A. MUDGE, JR., M. D.

Kenosha, Wisconsin

THE DEVELOPMENT of edema refractory to the usual therapeutic agents is not uncommon among patients with severe congestive heart failure. Recently we observed a patient with congestive failure who was refractory to mercurial and thiazide diuretics administered either singly or in combination. The addition to the therapeutic regimen of a new 17-spirolactosteroid was extremely useful in this patient. This drug apparently blocks the renal effects of aldosterone, the adrenal sodium-retaining, potassium-excreting hormone.[1-4]

Case Report

A 49-year-old white male was admitted to the hospital on Mar. 3, 1959, because of progressively increasing congestive heart failure which began to cause symptoms in November of 1955. He was well controlled with Digitalis and various diuretics up to three months prior to admission when he became progressively more refractory to therapy.

His pulse rate was 120 per minute and irregular. Blood pressure was 118/80 mm. of Hg. He had orthopnea, the neck veins were distended and there was dullness to percussion over the left lung base posteriorly. Moist rales were heard in the lower half of the left lung field and at the base of the right lung field. The heart was enlarged to the left mid-axillary line with the point of maximal impulse in the sixth intercostal space. No thrills were palpable. The heart sounds were distant, no murmurs were heard, A_2 was equal to P_2. The liver was palpable 5 cm. below the right costal margin. There was four plus pitting edema of the lower extremities and two plus pitting edema of the abdominal wall and edema of the penis and scrotum.

Significant laboratory data were as follows: Hyposthenuria, slight proteinuria, decreased excretion of phenolsulonphthalein; elevated hematocrit and blood nonprotein nitrogen level; normal serum proteins, thymol turbidity test, white blood cell count and differential.

The chest x-ray of Apr. 9, 1959, was reported as follows: Extreme cardiac enlargement; cardiothoracic ratio 20.6/30; left pleural effusion; a small amount of fluid in the right minor fissure; marked pulmonary vascular congestion.

A chest x-ray film on May 23, 1959, was reported as follows: Minimal decrease in transverse cardiac diameter, less vascular congestion; considerable decrease in the amount of fluid in the region of the posterior costophrenic sulcus.

An electrocardiogram on Dec. 18, 1959, was read as follows: Rate 120, totally irregular rhythm, left axis deviation, horizontal heart position. Impression: Atrial fibrillation, ventricular ectopic systoles; no significant change since Nov. 13, 1959.

He was treated vigorously (see Fig. 1); but by the 16th hospital day, even though his weight had decreased from 154 to 137 pounds, he still had massive edema. During the next three weeks he showed no further response to various modifications of his treatment including the use of corticosteroids.

On the 38th hospital day, spironolactone* 300 mg. per day was added to the therapy of prednisone and ammonium chloride. By the 42nd hospital day his weight had decreased to 130 pounds. He was then given chlorothiazide, 2 gm. per day in combination with spironolactone and prednisone, and he had a further drop in weight to 122 pounds. Spironolactone administration was discontinued on the 47th hospital day, but

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*Aldactone® (brand of spironolactone) supplied by G. D. Searle and Co., Chicago, Illinois.

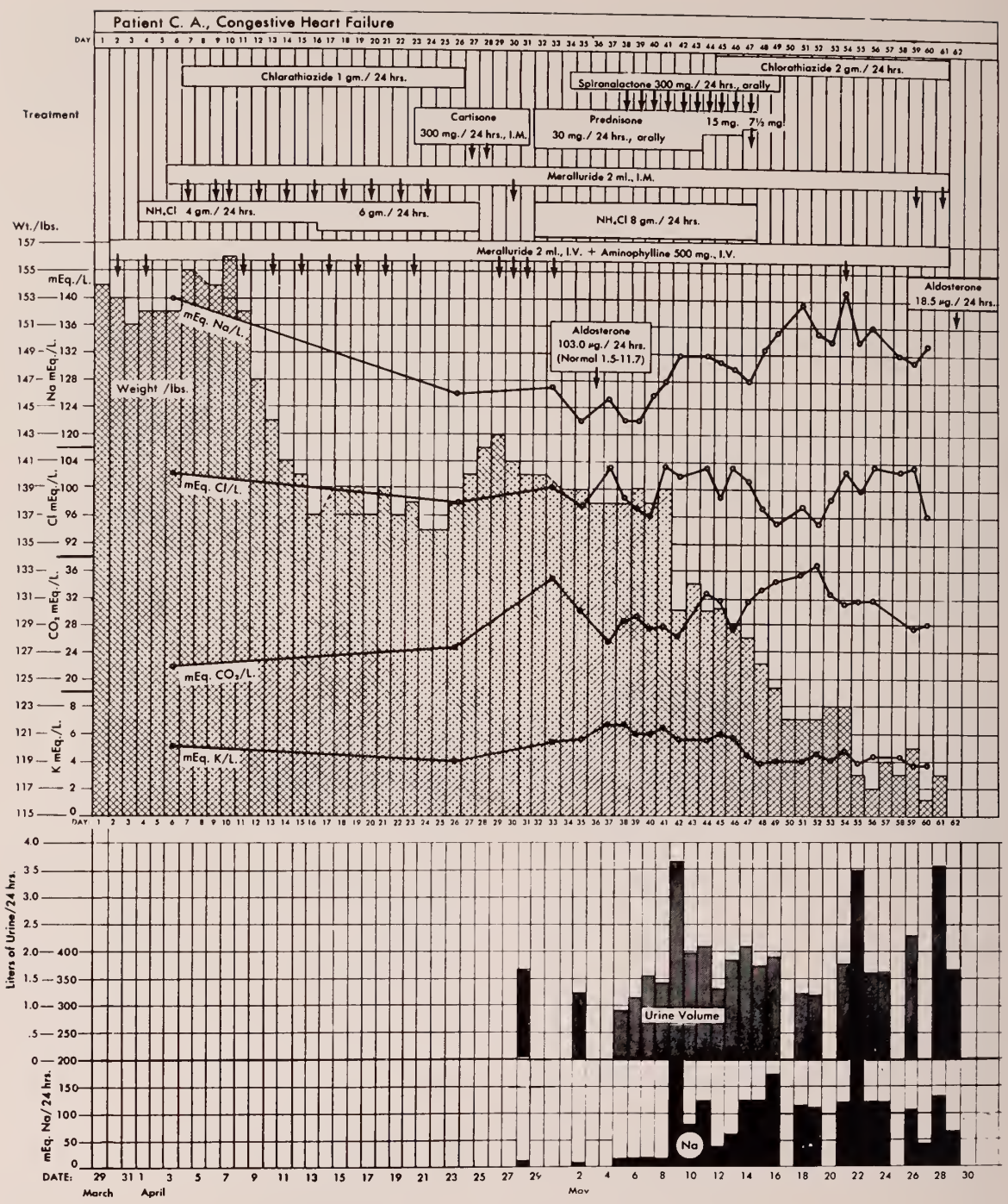

Fig. 1—Clinical course and therapy during first hospitalization.

the chlorothiazide therapy was continued through the remaining period of hospitalization. The patient was edema free on the 56th hospital day and discharged on the 62nd hospital day. A significant drop of his urinary aldosterone from 103.0 mcg. per 24 hours to 18.5 mcg. per 24 hours was noted.**

Four months after discharge he weighed 130 pounds, but was free of edema. Five months following discharge he slowly began to re-accumulate fluid. He was admitted to the hospital again six weeks later.

**Aldosterone analyses were performed by Bio-Science Laboratories, Los Angeles, Calif. (Normal urinary aldosterone values for this laboratory are 5 to 15 mcg. per 24 hours).

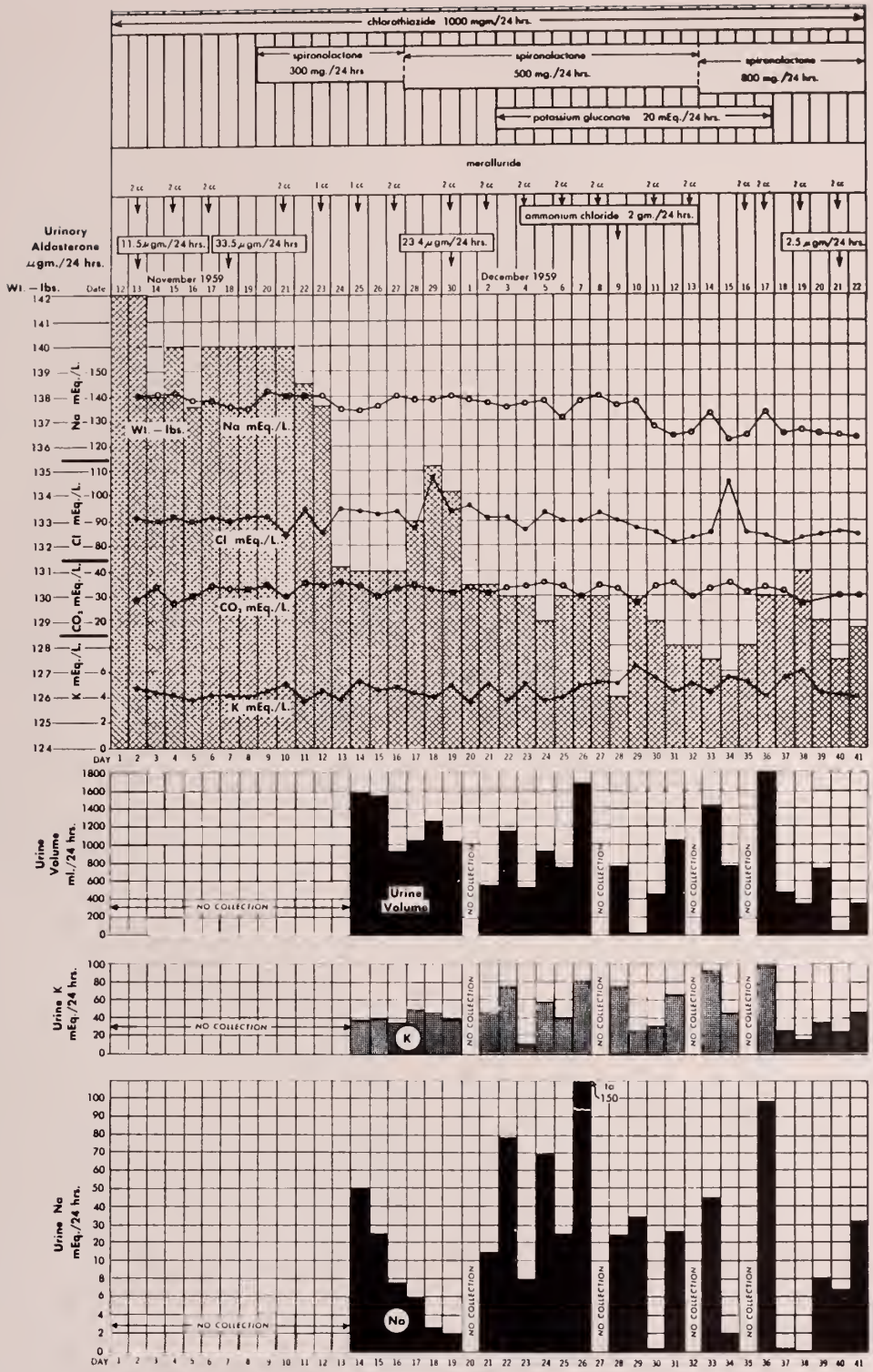

Fig. 2—Clinical course and therapy during second hospitalization.

The patient's physical condition was much the same as at the time of his previous admission. His clinical course and pertinent laboratory data are shown in Figure 2.

The initial urinary aldosterone was 11.5 mcg. per 24 hours. This increased sharply with meralluride therapy, but slowly returned to normal with diuresis. He had no

weight loss with meralluride and chlorothiazide, but did when the spironolactone was added. However, he still had slight edema of the extremities at the time of discharge.

A week later, he was re-admitted to the hospital with the chief complaint of abdominal pain. He had edema and ascites. The physical findings were the same as those found on previous hospital admissions. The pain was due to liver engorgement. He died suddenly on the morning of Jan. 1, 1960, and an autopsy was obtained. In addition to the usual visceral congestion associated with congestive heart failure, significant autopsy findings were in the myocardium and the adrenal glands. There was diffuse and focal myocardial necrosis with interstitial fibrosis. The cardiac valves were normal and the coronary arteries were widely patent. The adrenal glands showed focal hyperplasia of the zona glomerulosa. The zona fasciculata appeared widened with a questionable increase in lipid content.

The final impression was that the cardiac disease was due to idiopathic myocardial necrosis and fibrosis.

Discussion

The mechanism of refractoriness of patients with congestive heart failure to mercurial and thiazide diuretics is only partially understood. It has been demonstrated[5] that most patients with edema excrete abnormally large amounts of aldosterone in the urine. Bartter[6] has shown evidence for the existence of volume receptors in the thyrocarotid arteries of the dog which may be responsible for the initiation of secondary hyperaldosteronism; and Farrell[7-9] has extracted substances from pineal gland and diencephalic tissue which may influence aldosterone secretion rates when injected into dogs. Yankopoulos et al.[10] have shown in crossed circulation experiments that a humoral agent stimulates the adrenal cortex to secrete aldosterone. Davis[11] has used cross circulation techniques to show that the elusive "adrenoglomerulotropin" originates in the kidneys. Apparently the reduction in "effective" blood volume incident to heart failure induces the production of a hormone by the kidneys which is capable of stimulating aldosterone secretion.[10-12] The nature of these mechanisms is as yet unknown. Bartter[13] has shown that the injection of a mercurial diuretic, when it produces a sodium diuresis, will stimulate an increased aldosterone production.

On the 36th hospital day, the urinary aldosterone excretion of this patient was 103 mcg. per 24 hours, approximately 10 times the normal amount. This suggested that aldosterone might be the antidiuretic mechanism responsible for the refractoriness of this patient to diuretic therapy. Liddle[1,2] and Kagawa[3,4] and others have presented evidence that certain 17-spironolactosteroids specifically block the effects of aldosterone on the kidneys. The administration of spironolactone in conjunction with chlorothiazide and mercurial diuretics produced a significant diuresis in this patient. After the patient had experienced further diuresis, he again became responsive to conventional diuretics. At this time, the urinary aldosterone excretion had decreased to 18.5 mcg. per 24 hours. Wolff[14] reported both a rise and fall in urinary aldosterone excretion in patients with congestive heart failure undergoing diuresis. The status of cardiac compensation of the patient appeared to be the controlling factor. The observation in this patient is consistent with Wolff's data. With the patient's diuresis and as his cardiac status improved clinically there was a return of the urinary aldosterone toward normal.

Figure 1 shows two points of significance. First, there was a definite lag between the time of initial administration of spironolactone and the onset of its activity. The patient did not exhibit any weight loss until four days after spironolactone therapy was begun. This is also noted in Figure 2 and is consistent with the reports of others.[2,3] During the initial diuresis with the conventional diuretics, the serum sodium declined significantly to 122 mEq. per liter. Following the administration of spironolactone in association with prednisone, the serum sodium rose to 134 mEq. per liter despite the massive diuresis. Morrison[15] has suggested that this is chiefly the effect of prednisone. The serum potassium remained normal throughout the therapy.

Figure 2 shows an interesting phenomenon. The initial urinary aldosterone was almost normal, rose slightly during mercurial therapy and subsequently declined with use of spironolactone. Here again the initiation of spironolactone therapy was followed by the diuretic effect beginning on the fourth day.

Despite the 2.5 mcg. 24-hour urinary aldosterone level, the patient was not edema free on discharge and subsequently became completely refractory to all therapy just prior to demise.

Summary

A case report is presented of a patient with congestive heart failure due to idiopathic myocardial fibrosis who became refractory to mercurial and thiazide diuretics and prednisone. His urinary aldosterone excretion was greatly increased at this time. He achieved a diuresis when an aldosterone antagonist was added to his previous diuretic therapy suggesting that aldosterone was a significant factor in the resistance of his edema to therapy. Diuresis was accompanied by a significant decrease in his urinary aldosterone excretion.

This sequence of events was repeated during a second period of hospitalization. Eventually the patient became unresponsive to all diuretic therapy.

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ACKNOWLEDGMENT: I wish to express my appreciation to William W. Engstrom, M.D., professor of medicine and chairman of the Department of Medicine, Marquette University School of Medicine, for his help and encouragement.

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More Preventive Surgery Advocated

Mr. Jonathan E. Rhoads, chairman of the Department of Surgery of the University of Pennsylvania School of Medicine, advocates more use of preventive surgery.

Doctor Rhoads believes that if the social mores and psychologic outlook of the public could be changed drastically, surgery could be vastly extended and save many more lives.

As reported in *Medical News*, Doctor Rhoads would extend four major types of preventive surgery now practiced:

(1) Removal of gastric ulcers if they do not respond within three weeks to medical treatment; about 10 per cent of such lesions eventually become malignant.

(2) Immediate surgical removal of all polyps of the upper colon which cannot be reached by proctoscope. Of these lesions, 6 per cent are found to be malignant when first seen, and another 24 per cent must be removed later because of cancer or other disease.

(3) Removal of gallbladder stones, which are frequently associated with cancer. Doctor Rhoads added that this situation is complicated by the fact that "nobody knows whether the stones cause cancer or cancer causes the stones."

(4) Removal of all thyroid nodules—warranted by the frequency with which the lesions become malignant.

Doctor Rhoads noted that 30 per cent of surgical procedures performed today are intended to prevent rather than cure or palliate disease—Reprinted from *Texas State Journal of Medicine*, July, 1961, page 592.

Toxemia?

By F. J. HOFMEISTER, M. D.
and
R. MURRAY, M. D.
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APPROXIMATELY 6 to 7 per cent of all pregnancies are complicated by toxemia.[1] In spite of emphasis on exacting prenatal care and great advances in therapeutics, toxemia, along with sepsis and hemorrhage, remains a member of the triad of complications responsible for the vast majority of maternal deaths. The classic signs of edema, hypertension and albuminuria have been committed to memory by every medical student as the signal signs of probable complications. Such additional factors as urinary output, age, eye signs, facies, nausea and vomiting, upper abdominal pain and headache are additional aids to the diagnosis and management of the patient and often assist in establishing the prognosis. Convulsions and/or coma herald the progression of preeclampsia to eclampsia, necessitating more intensive therapy and indicating the potential of a markedly increasing morbidity and mortality of both mother and fetus. Presented herein is a case of maternal disease during gestation characterized by many of the signs and symptoms enumerated above. Despite therapy thought to be adequate and in keeping with present concepts of toxemia, there was rapid progression to the most unsatisfactory result possible, maternal death.

Case Report

The patient was a 29 year old gravida IV, para III, white woman, with expected date of confinement Sept. 8, 1959, who entered the hospital as an emergency by ambulance Sept. 16, 1959, at 12:16 p.m. She had been transferred from a hospital in a small nearby community, where an attempt at induction of labor with castor oil, quinine, enemas, and intravenous oxytocin (Pitocin) drip on Sept. 14, 1959, had been unsuccessful. On Sept. 15, 1959, x-ray films revealed a single intrauterine pregnancy at term in left occipito-anterior position with adequate maternal bony pelvis. Laboratory studies on that date revealed normal hemoglobin, red blood cells, white blood cells, and differential. Urinalysis showed many white blood cells but no sugar, albumin or acetone.

Past history revealed that the patient had been severely edematous during her three previous pregnancies, but no hypertension or albuminuria had been noted. She had one living child, a female delivered at term, the product of her second pregnancy. The first pregnancy ended in a postmature stillborn delivered at 43 weeks' gestation, and the third pregnancy in a seven months' stillborn.

During her fourth and final pregnancy (Table 1), the patient first saw her family physician on Feb. 12, 1959, at which time she weighed 162 pounds (normal weight 159); blood pressure was 140/88; there was no edema, and urinalysis was negative. On May 22, 1959, the patient's weight was 182 pounds and 2+ ankle edema was noted, but urinalysis was negative; blood pressure was 136/72. She was started on a regimen of salt restriction, chlorothiazide (Diuril), and later hydrochlorothiazide (Hydro-Diuril). However, on June 23, 1959, the edema had increased to 3+ and by Aug. 10, 1959, to 4+. It remained at this level in spite of all the diuretic measures utilized. Twice during the pregnancy it was necessary to hospitalize the patient because of severe headaches, gastritis, and dehydration. On Sept. 9, 1959, she weighed 191½ pounds, edema was 4+, blood pressure 126/80, and a trace of albumin was present in the urine. Hence, induction of labor was indicated.

On admission to this hospital, the patient had 4+ ankle edema and an edematous and puffy facies. She answered questions poorly and her sensorium seemed dull, but she did state that she had been unable to wear her wedding ring for some time and that she suffered from headaches. Blood pressure was 110/88, pulse and respirations normal. A strong acetone odor of the breath was noted. Fetal heart thumps were 140; fetal move-

From the Department of Obstetrics and Gynecology, Marquette University School of Medicine and Milwaukee Hospital.

TABLE 1—*Prenatal Data*

Date	B. P.	Weight*	Edema	Albumin	Ht. of Fundus
Feb. 12	140/88	162 lb.	0	0	
April 23	136/80	171	0	0	4 mos. size
May 22	136/72	182	++	0	24 cm.
June 23	126/80	182	+++	0	
Aug. 10	130/80	195	++++	0	27 cm.
Aug. 24	123/80	190	++++	0	26 cm.
Sept. 9	126/80	190	++++	+	26 cm.

*Normal 159 lb.

TABLE 2—*Laboratory Data Sept. 16, 1959*

URINALYSIS		HEMATOLOGY		CHEMISTRY	
Sp. G.	1.008	Hgb.	14.6 gm.	NPN	35 mg.
Albumin	10 mg.	Hct.	42	Uric Acid	8.2
Sugar	Trace	WBC	12,750	T. Prot.	6.82
Acetone	0	Seg	82	Alb.	3.67
RBC	0	Stab	1	Glob.	3.15
WBC	Rare	Lymph	12	Na	142
Casts		Mono	5	K	3.2
granular	4-5 l.p.f.	Eosino	0	Cl	103.5
hyaline	8-18 l.p.f.	Baso	0	CO_2 Comb.	16.5
		Platlets	Normal	T. CO_2	17.8
				pH	7.48

ments were felt by the examiner. The cervix was dilated 1 cm. with the head not engaged.

Laboratory studies on admission (Table 2) revealed strongly positive acetone, and 75 mg. per 100 ml. albumin in the urine, hemoglobin 14.6 gm. per 100 ml., hematocrit 42%, white blood cell count was 12,750 per cu. mm. with normal differential. Nonprotein nitrogen was 35 mg. per 100 ml., uric acid 8.2 mg. per 100 ml., total protein 6.82 gm. per 100 ml. with albumin 3.67 gm. and globulin 3.15 gm. Serum electrolytes were sodium 142 mEq. per liter, potassium 3.3 mEq. per liter, chloride 103.5 mEq. per liter, carbon dioxide combining power 16.5 mEq. per liter with total carbon dioxide 17.8 mEq. per liter, and blood pH was 7.49.

The patient was started on a regimen of bed rest, low-sodium diet, sedation with phenobarbital, 30 mg. three times a day, and periodic recordings of blood pressure and urine albumin and acetone. Because of dehydration and acetonuria, 2,000 ml. of a solution of 5% dextrose in water was given intravenously, following which she seemed more comfortable and rested. At 4:30 p.m., she complained of severe headache and developed generalized shaking or twitching for about one minute; blood pressure was 120/78. At 5:30 p.m., this began to recur at frequent intervals, between which she appeared to be dozing. At 6:20 p.m., equally hyperactive patellar reflexes were noted, and 8 gm. of magnesium sulfate was administered by deep intramuscular injection. At 7:15 p.m., the blood pressure was 152/82, fetal heart thumps were good and the fetal head was still floating. Twitching had diminished and the lungs were clear to auscultation, although respirations seemed noisy.

Preparations were made for the administration of hydralazine (Apresoline) and cryptenamine (Unitensin) intravenous drip according to the method of McCall[2] if the blood pressure should rise again. At 8 p.m., the patient's respirations became more noisy and labored, but no twitching was noted. At 8:05 p.m., she was deeply cyanotic and gasping for breath, with fists clenched and clear fluid bubbling from her mouth. An attempt was made to clear the pharynx manually with mouth-to-mouth breathing initiated. She was transferred to the delivery room, where the pharynx was suctioned and oxygen administered.

The anesthesiologist inserted an endotracheal tube and performed a tracheobronchial toilet, flushing the trachea with saline solution in an effort to remove any acid stomach contents present. Prior to this a few gasping attempts at respiration were noted, but because of deep cyanosis, artificial respiration by manual breathing bag compression was carried out. There was marked improvement in skin color but no attempts at spontaneous respiratory activity, so the Bennett respirator was employed.

Medical consultation was obtained for assistance both in diagnosis and management, since the fulminating progress of the patient's disease, in spite of the relatively low-grade hypertension and minimal albuminuria, indicated the presence of some factor in addition to toxemia. Five hundred ml. Group O Rh negative low titer whole blood was administered because of blood pressure decline to 70/50, with rapid return to 100/70. Urine albumin was 100 mg. per 100 ml. and output was good. The fetal heart thumps had dropped to around 70 per minute during the period of apnea and cyanosis, but returned to 120 to 130 per minute following maternal artificial respiration and transfusion; the maternal heart rate was 100 to 140 per minute throughout. Amniotomy was done in an effort to decrease intra-abdominal pressure and improve pulmonary ventilation, with a large amount of colorless fluid obtained; fetal heart thumps remained good.

TABLE 3—*Laboratory Data Sept. 17, 1959*

BUN	9 mg.	Na	135
Ca	9.4	K	2.8
P	3.4	Cl	92.6
Transaminase	27	CO_2 Comb.	18.8
Amylase	75	Total CO_2	20.6
		pH	7.42

A nasogastric tube was inserted and 200 ml. of dark green gastric contents obtained. Both pupils were dilated and fixed; the ocular fundi were normal in appearance. Breath sounds were diminished to absent over the entire left hemithorax with dullness in the left base; coarse rales were heard over the lower right lung. No corneal, deep tendon or Babinski reflexes were present. Electrocardiographic studies revealed low voltage and S-T and T wave changes suggestive of myocardial change. Lumbar puncture revealed clear fluid with pressure of 275 mm. water. Because of this increased pressure, no fluid for studies was taken. Portable chest x-ray films revealed pneumonitis in the right midlung field and total atelectasis of the left lung. The diagnoses entertained by the medical consultant were: (1) eclampsia, (2) aspiration pneumonitis and atelectasis, and (3) cerebral anoxia.

The patient was digitalized rapidly intravenously and blood pressure maintained with infusions of plasma and metaraminol (Aramine) by intravenous drip. Cut-down was performed to insure adequate flow. Tracheotomy was performed to reduce pulmonary dead-air space, and then a bronchoscopy carried out.

A large amount of fluid was aspirated from the left main-stem bronchus, but no mechanical obstruction was found. The tracheostomy tube was connected to the Bennett respirator, and penicillin was begun intramuscularly. Urine output was adequate, with progressive decrease in albuminuria (Table 3).

Vital signs remained unchanged except for temperature of 102 F. rectally at 11 a.m. Sept. 17, 1959, (Table 4). Laboratory studies Sept. 17, 1959, revealed blood urea nitrogen 9 mg. per 100 ml., calcium 9.4 mg. per 100 ml., phosphorus 3.4 mg. per 100 ml., serum transaminase 27 units, and serum amylase 75 units. Electrolytes were sodium 135 mEq. per liter, potassium 2.8 mEq. per liter, chloride 92.6 mEq. per liter, carbon dioxide combining power 18.8 mEq. per liter, total carbon dioxide 20.6 mEq. per liter, and blood pH 7.42. At 11:25 a.m., the patient became deeply cyanotic and her lungs were filled with moist rales. Blood pressure, pulse and fetal heart thumps were not obtainable, and the patient was pronounced dead at 11:32 a.m. Permission for autopsy was granted.

TABLE 4—*Albuminuria and Urine Output*

Date	Time	Albumin (mg./100 ml.)	Output of Urine (ml.)
Sept. 16	2:30 p.m.	75	120
	7:10 p.m.	30–100	
	8:50 p.m.	100–200	300
	10:45 p.m.	100	60
Sept. 17	12:30 a.m.	30	100
	5:25 a.m.	30	
	9:45 a.m.	30	
	11:00 a.m.	negative	750
			Total: 1,330 since admission

Autopsy Findings

At autopsy, acute congestion of liver, spleen and kidneys was found; but no changes typical of toxemia were present. Most significant were findings in the respiratory and central nervous systems. The left lung weighed 640 gm., the right 410 gm. Both lungs showed extensive areas of atelectasis and congestion; and microscopically there was early diffuse acute inflammatory infiltrate, chiefly neurophilic. In addition, acute, hemorrhagic, necrotizing tracheobronchitis was present. On opening the calvarium, no evidence of extra- or subdural hemorrhage or hematoma was noted. However, the brain was edematous and tense with distinct flattening of gyri and loss of sulci. It weighed 1,470 gm. The left frontal lobe was almost completely replaced by a tumor mass which was firm, indurated, nodular, pale grey-white tissue, distinctly glial in character. In other areas of the left cerebrum, smaller areas of comparable character were evident. Microscopically, the tumor was classified as a fibrillary astrocytoma.

Comment

The case presented illustrates the ease with which primary central nervous system disease, in this case brain tumor, can be confused with toxemia when it occurs during pregnancy. This confusion in diagnosis, with resultant delay in treatment, may be of critical importance in the outcome of the patient with both a pregnancy and an intracranial neoplasm. Had the possibility of brain tumor been considered and investigated in this case,

the outcome for mother and fetus might have been different.

Eastman[1] states that pregnancy and labor generally exert no ill effect on brain tumors. Other authorities believe that the increased intracranial pressure during labor may be harmful. Rand and Andler[3] state that gliomas, into which group the lesion herein reported would fit, grow more rapidly during pregnancy. Cushing apparently felt the same way, stating: "Pregnancy appears to be a not uncommon provocative element in bringing tumors to light, more particularly angiomatous lesions."[4] The chief unsolved question concerning the effect of pregnancy on the neoplasm concerns the degree to which apparent tumor growth is caused by associated edema as compared to the growth stimulus offered by the hormones of pregnancy. Hormonal stimulus seems to affect more immature cell types to a greater degree. Thus, glioblastoma is markedly stimulated but oligodendroglioma very little affected. That such changes in tumor size are related to pregnancy, rather than a part of the usual progress of the neoplasm, is suggested by the case reported by Bernard.[4] A woman who had a convulsion on the day after delivery had no further difficulty until the end of her next pregnancy when she became comatose on the expected date of confinement. A Cesarean section was performed five days later, and she died 60 hours postoperatively. Autopsy revealed a brain tumor, classified as a cholesteatoma.

TABLE 5—*Differential Diagnosis of Toxemias and Brain Tumors*

Toxemias	Brain Tumors
1. Headache generalized; usually bifrontal	1. Headache frequently generalized, may be focal
2. Nausea and vomiting may occur with equal severity any time of day or may occur only in morning	2. Nausea and vomiting may occur in morning only
3. Albuminuria	3. Normal urine
4. Neurologic examination shows abnormality slight and usually bilateral	4. Neurologic examination may show localizing signs limited to one side of body
5. Visual fields usually normal	5. Visual fields may show particulate defects in certain quadrants
6. Fundi may show retinal sheen or exudates early and papilledema late	6. Fundi show venous engorgement early and papilledema late
7. Blood pressure usually elevated	7. Blood pressure usually normal; is elevated late and then is associated with hradycardia
8. Convulsions usually generalized immediately and more common than with brain tumor	8. Convulsions may start on one side and be accompanied by definite aura
9. Electroencephalogram normal in 97% of cases	9. Electroencephalogram frequently abnormal with delta wave activity frequently indicative of tumor if lesion not located deep
10. Skull x-ray films normal	10. Skull x-ray films may show displacement or erosion of normal structures
11. Arteriograms normal	11. Arteriograms should show abnormal vascular pattern
12. Spinal fluid normal, in absence of hemorrhage	12. Spinal fluid may show elevated pressure (Danger!) and protein
13. Pneumoencephalograms, ventriculograms normal	13. Pneumoencephalograms, ventriculograms usually abnormal (Danger!)

Diagnosis

An awareness that brain tumor and pregnancy may co-exist is the most important step in making the diagnosis. This is more difficult than might be supposed, because of the frequency with which pregnancy with toxemia is seen, and the comparative rarity of brain tumor during gestation. However, the problem is not seen as rarely as might be supposed since three cases occurred in the state of Wisconsin during 1960,[5] including the case reported. The other two cases, also fatal, were an astrocytoma and a cerebral ependymoma. When the similarity of signs and symptoms encountered in the two conditions is considered, the ease with which the diagnosis may be missed is more readily understood.

The problem of differential diagnosis in this particular case was complicated by the persistent edema which had been treated by the prolonged use of a diuretic agent administered over a period of four months. Because of this, the semicomatose state of the patient on admission, and the relatively minor elevation of the blood pressure, the diagnosis of hypopotassemia was a primary consideration.

The differential diagnosis of toxemias and brain tumors is summarized in Table 5, modified from that which appeared in Clark's review of the subject.

Perhaps the laboratory findings in the case presented provided a clue to the correct diagnosis which was overlooked. The pH recordings of 7.48 and 7.42 are inconsistent with what might be expected, especially in view of carbon dioxide combining power of 17.8 mEq. per liter. Gambino[6] states that "usually an unexplained severe alkalosis is related either to peritonitis or to a serious central nervous system lesion."

Treatment

Treatment consists in the surgical removal of the neoplasm as soon as the diagnosis is made, regardless of the length of gestation. Therapeutic abortion is not considered indicated. General measures employed in the management of toxemia, such as diuretics and low-salt diet, may coincidentally lower intracranial pressure with transient improvement in the presence of an edematous tumor.

Summary

A case of brain tumor is presented, wherein the diagnosis was obscured by the patient's parturient state, and the signs and symptoms present attributed to toxemia.

The necessity for complete neurological examination of any patient with persistent headache of undetermined origin, whether pregnant or not, is illustrated.

Funduscopic examination is an important part of the examination of the patient with symptoms of toxemia.

Lumbar and cisternal puncture, pneumoencephalography and ventriculography are dangerous in the presence of papilledema.

The most important factor in the diagnosis of brain tumor during pregnancy is an awareness that such lesions exist. Three maternal deaths in Wisconsin in 1960 were caused by brain tumors.

Unexplained severe alkalosis may indicate a serious central nervous system lesion.

Treatment of brain tumor during pregnancy consists in immediate surgical removal.

(F.J.H.) 2212 West State Street.

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HYPERPARATHYROIDISM

Gilbert S. Gordan, M.D., associate professor of medicine, University of California School of Medicine, San Francisco. Excerpt from *Texas State Journal of Medicine*, July 1961, page 587.

The diagnosis of hyperparathyroidism proceeds in 3 steps. The first is clinical suspicion. Hyperparathyroidism should be considered in every patient with urolithiasis or nephrocalcinosis. The alert clinician will suspect hypercalcemia in patients with anorexia, nausea, constipation, weight loss, abdominal pain, nocturia, diabetes insipidus, muscular weakness, or psychosis. A reliable blood calcium determination is probably indicated in patients with refractory peptic ulcers or pancreatitis. The second stage in diagnosis is the demonstration of persistent hypercalcemia. This requires accurate calcium determinations. If the serum calcium level is elevated, serum proteins should be fractionated electrophoretically, both to detect cases of myeloma or sarcoidosis and to find the high $alpha_2$ and beta globulins characteristic of, but not specific for, hyperparathyroidism. The third and most difficult phase of the diagnosis is identifying those patients whose hypercalcemia is due to hyperparathyroidism and not to the manifold other conditions which more commonly cause hypercalcemia.

In our laboratory, detection of a urinary phosphate leak by measurement of the tubular reabsorption of phosphate has been reliable for this purpose. If the initial TRP is below 74 per cent and the patient does not have myeloma, sarcoidosis, vitamin D overdose, or uremia, the diagnosis can be looked upon as established. If the TRP has been raised into the normal zone by unsuspected low phosphorus intake, phosphate loading will produce a pathologically low TRP (below 74 per cent). In 22 per cent of cases roentgen examination shows subperiosteal reabsorption of the cortex, best seen on the radial surface of the middle phalanx of the index and middle fingers. This correlates fairly well with an elevated alkaline phosphatase level. Bone involvement can be shown in many more cases by tracer studies of bone mineral turnover and by bone biopsy. None of these individual findings is pathognomonic of hyperparathyroidism. Lack of direct measurement of parathyroid hormone forces us to use these indirect evidences of excess parathyroid hormone. Both the typical abnormalities of calcium and of phosphorus metabolism are necessary for the correct preoperative diagnosis of hyperparathyroidism, that is, hypercalcemia and renal phosphate leak. It is hoped that direct measurement of parathyroid hormone will make it possible to recognize hyperparathyroidism earlier, before irreversible and potentially lethal renal complications occur.

Physical Examination of College and University Employees Required

By JOSEF PREIZLER, M. D.
Madison, Wisconsin

THE NEW statutes extending the requirement for physical examinations including chest x-rays or tuberculin tests to all employees of institutions of higher learning became effective on September 24, 1961. Named specifically are the state university, state colleges, county teachers colleges, any privately supported institution of higher education granting a certificate, diploma or degree, and schools of vocational and adult education. An informal opinion of the attorney general's office states that schools of nursing also belong to this category. The only exception permitted under the new statutes is a person in an institution of higher education working less than 60 days in any school year.

The physical examination and chest x-ray or tuberculin test are made a condition of entering or continuing employment which the employing body must enforce. If the tuberculin test is positive, a chest x-ray is mandatory. New employees may submit proof of an examination, chest x-ray or tuberculin test taken within the past two years. A chest x-ray or tuberculin test must be repeated at least once every three years. Again, if the tuberculin test is positive, a chest x-ray is mandatory.

Doctor Preizler is director, Bureau of Communicable Diseases and Division of Tuberculosis Control, State Board of Health, Madison.

The physician making these examinations records his examination findings on a standard form prescribed by the State Board of Health (and State Department of Public Instruction for publicly supported institutions). This is furnished by the employer to the employee. (Forms may be purchased from the Eau Claire Book Company.) The report is retained in the physician's files and a confidential recommendation made to the employing body and to the employee on a detachable section of the standard report form. This includes a statement certifying that the person is free from tuberculosis in a communicable form as well as a recommendation that the person is physically suitable for employment.

The cost of the examination including the chest x-ray and tuberculin test is paid for by the individual employee of the institutions of higher learning. If the governing body wishes, it may arrange for the use of its facilities and qualified professional staff to carry out this function with or without charge to the employee.

A certificate of compliance on a form satisfactory to the State Board of Health must be filed with it not more than thirty days after the opening of each semester or similar period. A letter to that effect from the administrator of the school will be accepted as satisfying this requirement.

CANCER DETECTION FILM

A 15-minute film entitled "Cancer Detection: Proctosigmoidoscopy in Office Practice" was premiered at the A.M.A. clinical meeting in Denver, Colo., Nov. 27–30. Prepared by Drs. Emerson Day and Ralph E. Hertz of the Rectal-Colon Department of Surgery, Memorial Hospital, New York City, the 16mm. color-sound film covers the necessary equipment for routine proctosigmoidoscopy, home and office preparation of the patient for this procedure; and the examination itself which includes inspection and palpation, proctosigmoidoscopy, and withdrawal. The film is available to medical schools, medical societies, medical libraries, etc. upon request from C. B. Fleet Company, Inc., Lynchburg, Va., the sponsoring firm.

PRESIDENT'S PAGE

What Shall I Give?

IN HIS ESSAY on gifts Ralph Waldo Emerson stated his philosophy so well that to attempt to paraphrase his words could only be for the worse. Therefore, I shamelessly lift it bodily and for those who may be strangers to the Sage of Concord, quote him directly: "But our tokens of compliment and love are for the most part barbarous. Rings and other jewels are not gifts, but apologies for gifts. The only gift is a portion of thyself."

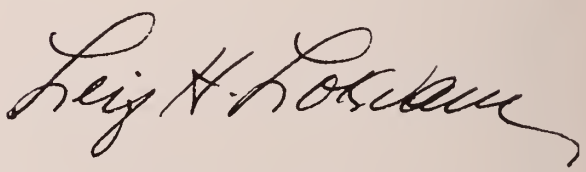
How often have you felt trapped and burdened by the too widespread custom of exchanging gifts at this special season or any season of the year? And how about the deluge of greeting cards? I refer, of course, to that which is beyond the circle of family, friends, the ill and shut-ins. I am convinced that the next flood to visit this world of ours will not be of water as Noah experienced but rather of paper and cards. How often as we perform this ritual have we not felt just a little guilty in the thought that we are doing this merely as an act of reciprocation? Surely there must be many ways to avoid the stigma of apologies for gifts and give a portion of ourselves.

A gift of a sum of money equal to the amount one usually allots for the purchase and mailing of greeting cards to help replenish the medical student loan fund in the Charitable, Educational and Scientific Foundation is most certainly one way to give a portion of ourselves. Another, is to do the same for the American Medical Education Foundation. Give of what we do best not only in our day-by-day services in our medical practice but gifts of our other talents—a friendly visit, a product from one of our skills and hobbies, a flower planted, a picture painted, a poem composed.

There are some who would have us believe that to do good is useless, to give of ourselves is hopeless and to use our talents as God has given us those talents is a waste. Paul Tillich, the theologian, tells us "Without the abundance of the heart nothing great can happen." He goes on to say that "the history of mankind is the history of men and women who wasted themselves (in service) and were not afraid to do so."

If we are to give a portion of ourselves, what then should be our portion? In this day of our times so full of gross materialism, increasing selfish demands both on an individual and collective basis, the tendency to want more than we give, all cause concern in our hearts and require more than a passing look at ourselves. What should be our portion? Our portion is gifts of service for with service we give of ourselves. This makes up the fabric of mankind. For in spite of the threat of the bomb and thermo-nuclear destruction, I would rather hold with Emerson in that "life is good fundamentally, and that nature and man could be trusted."

What shall I give? Give a portion of thyself!



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Cooperation in the Public Interest

AT A TIME WHEN segments of private medicine and public health agencies are glaring at each other, it is pleasant to report an area of happy cooperation between these groups. The Food and Drug Administration, an agency of the Department of Health, Education and Welfare, has recently been featured in the national press as standing side by side with the American Medical Association in its fight against medical quackery. This alliance is of long standing, and it has been productive of important results.

While the FDA may occasionally stray into fields where it has no business, it functions well under its primary responsibility of safeguarding the purity of foods and drugs. Unfortunately, the full story of the constant, watch-dog operation of the FDA is not generally known. Its publications are read namely by those professionally interested in public health and welfare and in the proper labeling of foods and drugs. Only in spectacular instances does the general public learn of the FDA. Nevertheless, the feeling of security with which most people buy and use any packaged product is in large part a tribute to the effectiveness of the FDA.

In the field of medical quackery, the FDA, with help from the AMA, has carried the fight against frauds in a highly commendable fashion. Its agents have used the power at their disposal to end quackery wherever it has been legally possible. They are credited with drafting important legislation to close the loopholes which exist in enacted statutes. The difference of opinion that exists between a government agency and private medicine as to the manner of providing health safeguards has never abridged a practical agreement as to what needs to be done.

Despite its importance to national safety, the FDA has never been famous for lush appropriations. It has had to squeak by, year after year, with minimum budgets, always a sitting duck for a congressional economy drive. When more congressmen take seriously the need for more rigid protection of the public's health, the Food and Drug Administration may get the appropriation its performance of a vital service deserves. It will be interesting then to see how much more benefit the nation will derive from this important agency. In the meantime, George P. Larrick, FDA Commissioner, and his staff are to be congratulated on a fine job.—D. N. G.

MEDICOLEGAL INFORMATION

AVAILABLE

Individual physicians or county medical societies may wish to make use of several informational materials and speakers on topics relating to medical-legal problems of physicians.

FILMS

The following films are available upon request to the State Medical Society of Wisconsin. Please allow at least two weeks advance notice if possible. These films were produced by Wm. S. Merrill Co. under direction of the American Medical Association, American Bar Association and American Hospital Association.

"Medical Witness"—Dramatically illustrates use of medical witness in court, providing do's and don'ts for effective testimony. Black and white, sound, 30 minutes.

"Doctor Defendant"—Suggests how the physician can prevent professional liability suits; shows county medical society grievance committee in action. Black and white, sound, 30 minutes.

"Man Who Didn't Walk"—Legal and medical aspects of personal injury case. Shows lawyers for plaintiff and defendant as they establish evidence from physicians, pretrial conference, and summation to jury. Black and white, sound, 30 minutes.

"A Matter of Fact"—Discusses the need for an adequate medical examiners' system versus the presently common coroners' system. Black and white, sound, 30 minutes.

"No Margin for Error"—Portrays certain aspects of physician-hospital activity bearing upon professional liability. Black and white, sound, 30 minutes.

"Chemical Tests for Intoxication"—Deals with the subject of chemical tests for intoxication and the introduction of the results of such tests in court. Black and white, sound, 30 minutes.

SPEAKERS

County medical societies interested in obtaining speakers on medicolegal subjects may contact the State Medical Society, Box 1109, Madison 1, Wisconsin (phone ALpine 6–3101), or the State Bar Association of Wisconsin, 402 West Wilson Street, Madison, Wisconsin (phone ALpine 7–3838).

LITERATURE

Copies of the following materials are available upon request to the State Medical Society of Wisconsin:

★ Interprofessional Code

★ Medicolegal Consent Forms (see January 1958 Blue Book issue of the *Wisconsin Medical Journal*)

★ Test Your A. Q. (Alcohol Quotient), 20 Questions on alcohol

★ Malpractice and the Physician

★ Medicolegal Aspects of Blood Transfusions

★ Medicolegal Aspects of Blood Grouping

Society Receives Award of Merit for Distinguished Service to History

THE STATE Medical Society of Wisconsin, on June 24, received an Award of Merit from the State Historical Society of Wisconsin for "distinguished service to history." Presentation was made at the annual meeting of the historical society in Prairie du Chien.

Cited by the historical society in the presentation were the Medical History Page in the *Wisconsin Medical Journal,* activities of the Section on Medical History in the collection and preservation of articles of historical significance, and establishment of the Museum of Medical Progress by the Charitable, Educational and Scientific Foundation.

Concerning the medical museum, the award continues ". . . the Society has been constantly alert to the need for improvement and expansion in the interest of faithfully telling the exciting story of the progress of medicine. . . . The result is and will increasingly become not only an educational experience but a memorial to a public-spirited, history-motivated, private professional organization."

For Distinguished Service to History

THE

STATE HISTORICAL SOCIETY OF WISCONSIN

presents this

AWARD OF MERIT

to

State Medical Society of Wisconsin

FOR THE DEVELOPMENT AND SUPPORT OF THE MUSEUM OF MEDICAL PROGRESS AT PRAIRIE DU CHIEN

Given in Madison, Wisconsin, this 24th day of June 1961

President

Director

SECTION ON MEDICAL HISTORY

AWARD OF MERIT

1961

Description

An organization is only as good as its purpose and its membership. Membership creates leadership and purpose concentrates energy. The State Medical Society of Wisconsin is remarkable for having achieved a high degree of excellence in purpose and membership, in leadership and concentration of energies.

With man came medicine, and the State Medical Society has dedicated itself to the purpose of reminding its constituency and the general public that man and medicine have an intertwined history. The Society has regularly reported on medical history in the pages of its *Journal.* It has created a Section on Medical History within its organization for those of its members who want to carry their historical interest further. The Society and the Section on Medical History, have stimulated the collection and preservation of medical books, documents and artifacts for the benefit of those who want carefully to study or casually to observe the development of medical progress.

The culmination of the Society's interest in history came with the establishment of the Museum of Medical Progress. Through the good offices of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin, the Society was able to acquire the restored military hospital building at the site of Old Fort Crawford in this city. Building on the good work of the Daughters of the American Revolution, and the Beaumont Foundation, both of Prairie du Chien, the Society applied funds to ready the restoration for exhibits, and constructed an administration building so that the site could be opened to the public. Since the Museum of Medical Progress opened on September 1, 1960, the Society has been constantly alert to the need for improvement and expansion in the interest of faithfully telling the exciting story of the progress of medicine. The State Historical Society, a partner in the enterprise, can testify to the persuasiveness and tenacity of the Medical Society's dedication to this project. The result is and will increasingly become not only an educational experience but a memorial to a public-spirited, history-motivated, private professional organization.

Citation

The State Medical Society of Wisconsin

Hub of health for humanity and moving spirit behind a museum of spirited medical progress, for recognizing that history and humanity are one, that the present and the past cannot be divided, the State Historical Society of Wisconsin is honored to present you this Award of Merit.

(Seal)

Presented at the Annual Meeting of the State Historical Society of Wisconsin on June 24, 1961, Prairie du Chien, Wisconsin.

Indian Peace Pipe for Medical Museum

This peace pipe, given to Dr. H. A. Sincock of Superior by Chief James Doolittle, is made of red clay; it measures 10 inches in length with a 3½-inch stack. Although it has several scratches and notches, it has been well preserved through the years.

MOST RECENT acquisition of the Section on Medical History is an item of considerable historical importance, a peace pipe received from Dr. H. A. Sincock, Superior. In making the presentation, Doctor Sincock writes:

"I received this Peace Pipe from Chief James Doolittle, at Odanah, Wisconsin, in 1913. It is the original pipe smoked between the Sioux Indians, and the Chippewa Indians on the night of August 22, 1862. This was the night before the massacre of the white settlers at New Ulm, Minnesota.

"The massacre took place on August 23, 1862. This was one of the few times the Sioux Indians and the Chippewas ever banded together to fight the white man. Chief Doolittle with his band from the Bad River, Wisconsin Reservation, would have no part in the massacre, which took place the following morning, so he withdrew.

"He gave me this Peace Pipe because I was able to stop a hemorrhage his daughter-in-law was having. I was called, after the Indian medicineman and their Indian mid-wife were unable to help. In desperation, they thought they would take a chance with the white man's doctor.

"Chief Doolittle felt so grateful because I was able to stop the hemorrhage, he presented me with this Peace Pipe.

"It is with a great deal of pleasure I am able to present the Peace Pipe to the Wisconsin Medical Museum."

The peace pipe has been added to a previous donation of Doctor Sincock, the regalia of a medicine man of the Chippewa tribe, presented to him when he was made an honorary member for his medical aid.

YOUR SUPPORT IS WELCOMED

Contributions to The Charitable, Educational and Scientific Foundation of the State Medical Society are tax deductible by the donor. Their use is supervised by an 85 member Board of Trustees and donors may earmark contributions for specific purposes. For information write to The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin.

THE MEDICAL FORUM

AMA Commends Wisconsin For Founding Medical Museum

The House of Delegates of the American Medical Association, meeting at Denver, Colorado, November 27–30, passed a resolution commending the State Medical Society of Wisconsin for the establishment of the Museum of Medical Progress at Prairie du Chien.

In other actions of specific interest to Wisconsin physicians, the House passed a resolution encouraging members and officers of state societies to visit the AMA headquarters in Chicago and referred to committee another resolution dealing with identification of persons eligible to participate in business sessions of section meetings.

Both resolutions were introduced by the Wisconsin delegation.

The first was an outgrowth of the November meeting of the Council and officers of the State Medical Society of Wisconsin at the Chicago AMA headquarters. The meeting, the first occasion on which the full Council and officers of a state society held its meeting at 535 North Dearborn Street, proved of such value that the Wisconsin delegation felt similar events for other state societies should be recommended.

The second resolution was brought about by the feeling that little verification of identification is being exercised at specialty group meetings, and could possibly result in such sessions being "packed" for purposes of passing resolutions advantageous to specific minority groups.

Intent of the resolution is to require proper identification of all members attending specialty section meetings at the AMA annual meetings to insure fair and just representations of bona fide specialists with the various specialty groups.

State Society Appointments Are Revealed

Three appointments to divisions and commissions of the State Medical Society have been announced.

Dr. L. M. Simonson, Sheboygan, has been named vice-chairman of the society's Commission on State Departments; Dr. Keith Keane, Appleton, has been named chairman of the Division on Nervous and Mental Diseases; and Dr. Charles Wunsch, Green Bay, is the new vice-chairman of that division.

The appointments were made by the Council at a recent meeting in Chicago.

Doctor Simonson, a pediatrician, is currently chairman of the Division on School Health of the State Medical Society. This and nine other divisions make up the Commission on State Departments of

(Continued on page 666)

WISCONSIN'S DELEGATES to the American Medical Association are shown above during a House of Delegates session at the recent Clinical Meeting held at Denver, Colorado. Seated in the left center portion of the picture (between the arrows) are, left to right: Dr. L. O. Simenstad, Osceola; Dr. A. A. Quisling, Madison; Dr. E. L. Bernhart, Milwaukee; and Dr. R. A. Galasinski, Milwaukee.

Society Cites 33 4-H Clubs

Thirty-three 4–H clubs in Wisconsin have been selected to receive the Health Achievement Award of the State Medical Society.

The Awards are presented in recognition of outstanding accomplishment in the 4–H health and safety program during 1961.

Each club receives a certificate signed by the presidents of the county and state medical societies. In addition they are awarded a year's subscription to *Today's Health*, the monthly magazine on general health topics published by the American Medical Association.

The award program is a project of the Commission on Public Relations and Communication.

Some of the outstanding record booklets are on display at the State Medical Society office in Madison. The State 4–H Office reports that from one-third to one-half of the 4–H members in the state actively participate in the health program each year.

State Society Appointments

(Continued from page 665)

which he is the newly named vice-chairman.

He has previously been chairman of the Committee on Maternal and Child Welfare for the state society, a member of an advisory committee to the State Welfare Department's Division of Children and Youth, and a member of the Subcommittee on the Disturbed Child.

Doctor Keane, a psychiatrist, has been a member of the Division on Nervous and Mental Diseases for nearly a decade. He has been on the staff of the student health department at the University of Wisconsin and served as resident psychiatrist for the Veterans Administration at the university. He was also acting director of the Dane County Child Guidance Center, director of the Sheboygan Guidance Clinic, and medical consultant to the Wisconsin State Division of Mental Health.

Doctor Wunsch, also a psychiatrist, has been a member of the Division on Nervous and Mental Diseases since 1953. He has also been a member of the Committee on Mental Health of the Brown County Medical Society, psychiatrist for the Wisconsin State Reformatory at Green Bay, and psychiatric examiner for the Veterans Administration.

The Division on Nervous and Mental Diseases works closely with the State Board of Health and Department of Public Welfare in mental health matters in the state.

The Commission on State Departments works with state agencies in such areas as aging, chest diseases, handicapped children, maternal and child welfare, public assistance, rehabilitation, safe transportation, school health, and visual and hearing defects.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 34

Museum Of Medical Progress

Introduced by: Willard A. Wright, M.D., Delegate, North Dakota Delegation

WHEREAS, The history of medicine is a remarkable story of triumph over adversity, of individual achievement, of man's eternal quest for knowledge and of the physicians' efforts through the art and skill of medicine to relieve human suffering; and

WHEREAS, The collection and preservation of medical history is of enormous benefit to historians, educators, practitioners and the public; and

WHEREAS, The proper presentation to the public of the story of medicine and its achievements through the centuries is an effective but little used method of communication on behalf of improved public relations for the medical profession; and

WHEREAS, The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin in collaboration with the State Historical Society of Wisconsin has created a Museum of Medical Progress at Prairie du Chien, Wisconsin, whose permanent and changing exhibits present a fascinating story of the achievements of science and medicine not only for the people of the North Central States but on behalf of all of American medicine; therefore be it

***Resolved*, That this House of Delegates applaud the establishment of the Museum of Medical Progress at Prairie du Chien, Wisconsin; and be it further**

***Resolved*, That the American Medical Association encourage state and county medical societies and physicians everywhere to develop and continue an active interest in the collection and preservation of medical history as a living vital means of expressing to the public the achievements of the medical profession in prolonging life and improving human welfare.**

Adopted November 28, 1960
Denver, Colorado

STATE AIR AMBULANCE SERVICE IS ANNOUNCED

An air ambulance service, available at Truax Field, Madison, for anywhere in the United States has been announced by DEC Aviation, Inc., of Madison.

F. R. Rodgers, Jr., of the company states that its new modern aircraft, adapted for a stretcher patient, cruises at 180 miles per hour. It is designed for short field take-off and landing so that all airports in Wisconsin may be utilized. Charge is 20 cents per mile for total round-trip mileage.

FOUNDATION IS CO-SPONSOR . . .

Four Hundred At Athletic Injuries Meetings

A total of 423 persons attended five athletic injuries clinics held around the state on Saturday, November 11.

The clinics were sponsored by the Wisconsin Interscholastic Athletic Association and the Charitable, Educational and Scientific Foundation of the State Medical Society.

Topics covered at each clinic were the same: value of training and conditioning, emergency care in athletics, and limitations on the care of injured athletes by coaches. The clinics were held at Fond du Lac, Richland Center, Stevens Point, Menomonie and Waukesha.

Speakers were:

FOND DU LAC: Doctors Ewald H. **Pawsat**, and Donald W. **McCormick**, both of Fond du Lac, and J. L. **Weygandt**, Sheboygan Falls.

RICHLAND CENTER: Doctors William H. **Bartlett**, Madison; H. W. **Carey**, Lancaster; and Dayton **Hinke**, Richland Center.

STEVENS POINT: Doctors F. W. **Reichardt**, Stevens Point; Albert J. **Molinaro** and Roy **Larsen**, both of Wausau.

MENOMONIE: Doctors Charles M. **Ihle** and Thomas E. **Kilkenny**, both of Eau Claire; and Max **Bachhuber**, Alma.

WAUKESHA: Doctors Bruce J. **Brewer**, Milwaukee; James C. H. **Russell**, Fort Atkinson; and Paul **Campbell**, Waukesha.

The program was under the direction of the Division on School Health of the Commission on State Departments of the State Medical Society.

ATHELTIC INJURIES was the topic of Dr. Dayton Hinke, Richland Center, at a clinic in that community on November 11. About 65 coaches and administrators attended the meeting, one of five held in the state that day.

INTERESTING FIGURES ON PHYSICIAN CALLS

A recent survey by Health Insurance Institute reveals that the average American consults a physician about his health five times a year.

Divided into geographical areas, persons in the Northeast average 5.4 visits, those in the Midwest and South 4.7 visits, and in the West 5.7 visits a year.

Meanwhile, another survey, undertaken by Medicare, the program of Federally paid medical care for dependents of servicemen, turned up some interesting figures on the length of stay in a hospital.

The average stay in New England is 6.9 days, while in the Far West it is only 4.8 days. For appendectomies, New England residents remain in the hospital 7.5 days, Great Lakes area residents 6.5 days, and Pacific Coast residents 5.1 days.

Janesville Schools Training Teachers In Mental Health

An in-service training program in mental health was conducted during the 1960 school year with 64 teachers of the Janesville Public Schools taking part.

The experimental effort was planned by a sub-committee of the State School Health Council consisting of Don **Wille**, La Crosse, and A. B. **Abramovitz**, Warren **Southworth**, James **Lewis** and Robert Van **Raalte**, all of Madison, along with Janesville Superintendent Fred **Holt** and Ely Sires, mental health consultant of the Department of Public Instruction.

The teachers, divided into four groups, met twice monthly using the outline "Suggested Guiding Principles on Emotional and Mental Health in the Schools," developed by the State School Health Council as a guide. They were encouraged to explore problems of immediate interest and concern.

ANSWERING QUESTIONS on athletic injuries are Dr. William Bartlett, Madison, center, and Dr. H. W. Carey, Lancaster, right. The two physicians were speakers at the Richland Center clinic on the subject held November 11.

HAVE YOU LOOKED AT YOUR INCOME PROTECTION LATELY?

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Continued Health Insurance In Retirement Important Factor In Health Care For The Aged

Most Blue Plans Offer Coverage for Retirees

Continued coverage for retired employees through their company's health insurance program is becoming an important factor in aiding elderly people to pay for the costs of health care, according to figures in a recent study at the University of Wisconsin School of Commerce.

The study was made by William L. Burdick in a thesis titled "Group Health Insurance for the Aged." It was financed in part from a $10,000 grant from the State Medical Society's Charitable, Educational and Scientific Foundation.

Burdick indicates that over 80 per cent of the Blue Shield and Blue Cross plans in the country underwrite continuation plans for retired employees. Thirty-five of the leading private insurance companies also provide such coverage.

COMMON IN LARGE GROUPS

Continuation plans for retired employees are more common in larger groups, the study shows, and more than 40 per cent of all employer and industry-wide groups provide some form of group health insurance benefits to retirees.

Nearly all of these groups provide hospital and surgical benefits to retired employees, the majority allow medical benefits, but only a few give major medical coverage.

Where the employer contributes to the cost of the program, in about half of the groups, the average amount paid by retirees is about $5.00 per month. Where the retiree pays the full cost, it ranges from $10.00 to $15.00 per month.

ROOM FOR IMPROVEMENT

There is still room for improvement in such plans, the study reveals.

Negotiations for the installation of such plans are conducted almost exclusively with the employer, and the interests of the retired employees may not be fully served in this method, Burdick states.

Also, the majority of these plans do not provide benefits for dependents of deceased retirees.

BENEFITS

In hospital benefits, the plans are about evenly divided between those which provide a semi-private room and those which pay a daily dollar maximum room benefit. Number of days care generally runs either 70 or 120 days. Miscellaneous charges are paid in full in about half the groups and either up to a maximum figure or on a co-insurance basis in the other half.

About two-thirds of the continuation plans make a maximum surgical payment of $250 to $300. The author comments that these amounts will provide nearly full payment for surgical procedures in the majority of cases. With more and more surgeons providing a reduced fee for aged patients, the author states, this will be increasingly true in the future.

Most continuation plans pay for in-hospital medical calls, generally limited to $5.00 per day with a maximum coverage ranging up to 120 visits.

WPS OFFERS PLANS

Wisconsin Physicians Service, the health care plan of the State Medical Society, currently offers both surgical-medical and hospital protection to retired persons through their employment groups.

In addition, WPS pioneered in offering coverage to individuals over 65 with its Century Plan. This is available to persons who held individual contracts, or whose groups did not provide coverage after age 65.

A RECOGNIZED NEED

Figures in the study reveal that there is a need for improvement in the health insurance mechanisms for providing for the needs of the person over 65, but that much progress has been made.

The medical profession has also recognized the need for a mechanism to provide for those who do not carry such insurance and are unable to meet the cost of catastrophic illness.

Through improved insurance techniques in the first case, and implementation of the Kerr–Mills Act in the second, the profession feels that the major needs of this age group will be met.

Oshkosh Daily Northwestern Photo

A CAREER IN MEDICINE was the topic of Edward Zernszack, right, Omro High School guidance director, at a "Careers Through the Year" program held at the school. The exhibit was obtained on loan from the American Medical Association. High interest came from the school's Medical Club, which has 35 members interested in careers in the health field.

Social Security Health Care For The Aged Backed At White House Regional Conference

Medical care for the aged under the social security mechanism took a back seat to agricultural problems, general economics and area redevelopment at the White House Regional Conference at Madison November 13.

But HEW assistant secretary Wilbur J. *Cohen* was on hand to make a pitch for the King–Anderson proposal and blast the AMA.

The conference was one of a series held by the administration throughout the nation to explain some of its programs and get "grass roots" opinion on them.

Cohen, speaking on Education and Welfare, as well as Health, based his remarks on the thesis that unless the United States is willing to spend considerably more money in these areas, we will become a second or third class nation.

Where will the money come from? "I don't think in a race for time you can be too concerned about fiscal methods," Cohen stated.

Taking a poke at the American Medical Association, he had this to say about the administration proposal: "No matter what kind of proposal you present someone is going to call it socialism."

"This is a phony issue, in my opinion," he added.

He urged the audience to "use the tried and tested social insurance method . . . the same as Blue Cross"—his description of the King–Anderson approach.

Concerning the Kerr–Mills Act—on which HEW has been significantly silent for the most part—Cohen answered a question by stating, "I think Wisconsin should take advantage of the Kerr–Mills bill." His reason was that this will provide aid for those aged not covered by social security.

Capitol Comment

RIBICOFF CONFIDENT

At the White House regional conference in St. Louis, Secretary of Health, Education and Welfare A. A. **Ribicoff** expressed confidence medical eldercare under social security will have a top priority on Capitol Hill this winter.

Assistant Secretary Wilbur **Cohen** told Maryland, Delaware, District of Columbia Hospital Association, "We are due for some important changes in the financing, organization and availability of medical services. . . ."

COMMENTS BY VICE PRESIDENT

Despite his reputation as a moderate in medico-political affairs, Vice President Lyndon **Johnson** not only believes today in enlargement of the Federal role but intends to make an intense personal effort for fulfillment of Administration aims in this field, states the November 27 *Washington Report.*

The vice president said government scholarships are imperative to prevent worsening of a shortage of doctors. Washington must provide new and larger grants for medical schools and "maintain its vigilant and constructive interest in medical research," he said. While he did not mention social security eldercare explicitly, Vice President Johnson inferentially gave it support, at same time denying it is socialized medicine.

Hippocratic Oath Is Outdated Declares Physician From Illinois

Is the Hippocratic Oath still adequate to serve as the foundation of medical ethical conduct?

This question was brought up recently by Dr. Max Samter, professor of medicine at the University of Illinois Medical School.

Of special concern to Doctor Samter is the technological revolution—"tests, computers and automatic controls replacing our fragile minds; teletypes and telephones the essential means of communication between physicians and patients."

"It is my belief we need a covenant between ourselves to stem this tide," he tells physicians, "and to return to a world of technological confusion some of the values which are the inheritance of our past and which should be carried into our future."

Doctor Samter questioned the deans of U. S. medical schools and found that one-third still swear by the Hippocratic Oath, one-third have adopted the Geneva version, and 18 schools do not administer it at all.

"Patients change, physicians change, society changes," Doctor Samter commented. "No covenant which applies to medieval physicians can be valid for our times."

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WHA Officers Are Urged To Stand Firm In Opposition To Social Security Mechanism

Officers, trustees and the AHA delegates of the Wisconsin Hospital Association were urged not to alter their opposition to the social security approach of financing health care for the aged in a November 29 letter from the officers and councilors of the State Medical Society.

The letter was prompted by an action of the American Hospital Association, authorizing a reappraisal of its present policy with respect to health care of the aged.

The special report, to be presented to the AHA House of Delegates in "about 90 to 120 days," is to include results of a study of "legislative possibilities of utilizing the social security mechanism without the objectionable provisions contained in bills thus far presented to the Congress."

Copies of the letter also went to the administrators and trustees of all Wisconsin hospitals and to the chiefs of staff.

The letter reads, in part:

"If there is even the slightest possibility that the AHA will give serious consideration to embracing the social security device for the care of the aged, we strongly urge that you strenuously oppose such a development.

"There is no question in our minds but what acceptance of any compromise proposal utilizing the social security device is a pleasant tasting but delayed reaction dose of national compulsory health insurance.

"As physicians our chief concern is with the well being of the patient. We know that this, too, is your goal. If a compulsory health insurance scheme in the guise of a Social Security health care program for the aged is accepted or imposed upon the hospitals of Wisconsin as part of a national plan, the ability of hospitals and physicians to serve the best needs of the patient will be adversely affected. We have long agreed that national compulsory health insurance endangers the quality of patient care. The reasons are many . . . loss of freedom, imposition of controls and restrictions, staggering over-utilization, emphasis on cost rather than quality . . . and you know, perhaps better than we, the special dangers of government control to the hospital and ultimately for the patient.

"We earnestly believe that the continued expansion and improvement of voluntary prepayment and insurance plans coupled with sound Kerr–Mills and public assistance programs will assure every elderly person in Wisconsin that he can obtain with dignity any necessary health care.

Educational Symposium of Medical Assistants

The Wisconsin State Medical Assistants Society will hold its third Educational Symposium on January 13 at Brooks Memorial Union, Marquette University, Milwaukee.

The program will start at 9 a.m. with a welcome by Mrs. Julia **Logerquist**, president of the society, and Dr. Roman E. **Galasinski**, president of The Medical Society of Milwaukee County.

"Medico-Legal Problems" will be the topic of Dr. T. H. **McDonell**, Waukesha, and Attorney Norman **Skogstad**, Milwaukee. Dr. Frank L. **Ziehl**, Milwaukee, will discuss "The ABC's of Laboratory Procedures," and Dr. Edward E. **Houfek**, Sheboygan, will close the morning program with "Patient-Medical Assistant Relationships as Viewed by a Psychiatrist."

Noon luncheon speaker will be Karl O. **Werwath**, president of the Milwaukee School of Engineering; his topic will be "Some Impressions and Implications of the Reform in Technical Education in the USSR."

On the afternoon program, Dawson S. **Blackmore**, West Central Region sales director for Eli Lilly and Company, will talk on "What Price Your Health." "Looking Into Your Future" will be the topic of John **Dickens**, Milwaukee.

THE COUNCIL OF THE STATE MEDICAL SOCIETY of Wisconsin met November 18 in Chicago, the first state society Council to hold such a meeting in the headquarters of the American Medical Association. Pictured above, clockwise from the head of the table, are: Dr. James C. Fox, La Crosse, chairman of the Council, 7th district; C. H. Crownhart, Madison, secretary; Dr. G. J. Schulz, Union Grove, 2nd district; Dr. W. J. Egan, Milwaukee, 12th district; Dr. R. C. Frank, Eau Claire, 10th district; Dr. H. J. Kief, Fond du Lac, 6th district; Dr. P. B. Blanchard, Cedarburg, 5th district; Dr. V. E. Ekblad, Superior, 11th district; Dr. W. J. Houghton, Milwaukee, 12th district; Dr. L. O. Simenstad, Osceola, delegate to the AMA; and (backs to camera) Dr. E. D. Sorenson, Elkhorn, past president; Dr. George Collentine, Jr., Milwaukee, alternate delegate to the AMA; and Dr. L. H. Lokvam, Kenosha, president. Right background are: Charles Johnson, AMA field representative; H. L. Toser, WPS insurance director; and Dr. F. J. L. Blasingame, executive vice president of the AMA.

INFORMATION FOR YOUR PATIENTS . . .

What Individuals Can Do In Civil Defense

News Briefs

BLUE SHIELD PAYS

The 75 Blue Shield Plans located in the United States and Canada paid out more than $415,200,000 for care rendered to members during the first six months of 1961, according to Lawrence C. Wells, director of promotional services for the National Association of Blue Shield Plans.

This represented more than 92 per cent of the total income of all plans, with less than 10 per cent of total income going for administrative expenses.

LEGISLATIVE FOOD FOR THOUGHT

In view of the chiropractors' attempts to come under Workmen's Compensation in the past session of the legislature, a recent case in Minnesota has considerable significance:

A Hudson, Wisconsin, widow was awarded $17,500 by the Minnesota Industrial Commission for the death of her husband following chiropractic treatment.

While at work for a Minneapolis firm, the man struck his head on the edge of a table. He went to a chiropractor for treatment and died about a month after the accident.

The opinion of the commission stated that "evidence is overwhelming that the employee went to the chiropractor to seek relief from the effects of the blow incurred" and that he "died as a direct result of the treatment rendered."

What can physicians do to aid the Civil Defense effort? One role is already established in the organization and staffing of mobile medical teams, 200-bed emergency hospitals, emergency treatment stations, and serving as county medical directors.

But there is another important role—giving out information to patients and other contacts.

FALLOUT SHELTERS

On the basis of available information, and the best predictions that can be made, the Office of Civil Defense has encouraged the public to construct fallout shelters. The current program is based on two facts:

1. With a certain number of assumed target areas in the country, and the fact that fallout will be carried hundreds of miles, no area in the nation can be considered safe from fallout.
2. Since a mass of material between a person and the fallout will cut down the amount of radiation that reaches that person, individuals can take protective action by building shelters.

On the surface this may appear to be a simple operation, but there are many problems connected with building a shelter, stocking it, and living in the confined space for a period of two weeks or more.

BUILDING A SHELTER

What is an adequate shelter?

"There is about the same amount of shielding in 8 inches of concrete, for instance, as in 12 inches of earth, 16 inches of books or 30 inches of wood," said William K. Chipman, Madison, State Civil Defense Director. "In most of the country, everywhere except in areas hit by the heaviest fallout, these thicknesses would give ample protection for a basement shelter."

Available from the OCDM is a pamphlet "The Family Fallout Shelter," giving instructions on construction of a basement concrete block shelter, an aboveground shelter, and different types of underground shelters.

Numerous local contractors also have plans available.

Cost estimates by the CD authorities range from $150 up, depending on the type of shelter and the amount of construction the individual is able to do himself.

Some special considerations in shelter construction are:

1. **Arrangement of the entrance.** It need not be sealed, but must have at least one right-angle turn to cut off direct radiation.
2. **Ventilation.** Vents in the wall and the open entrance in basement shelters provide ventilation, but a blower may increase comfort. A blower is essential for the double-wall and underground shelters.
3. **Radio reception.** It will be important to receive Conelrad information, and since recep-

(Continued on page 672)

DIRECTING SMS ACTIVITIES are members of the Council, shown above, during their November 18 meeting at the American Medical Association in Chicago. Left to right are: Dr. E. D. Sorenson, Elkhorn, past president; Dr. George Collentine, Milwaukee, alternate delegate to the AMA; Dr. Robert E. Callan, Milwaukee, speaker of the House of Delegates; Dr. Leif H. Lokvam, Kenosha, president; Dr. R. W. Mason, Marshfield, 9th district; Dr. E. J. Nordby, Madison, 3rd district; Dr. E. M. Dessloch, Prairie du Chien, 4th district; Dr. J. H. Houghton, Wisconsin Dells, 3rd district; and Dr. W. D. James, Oconomowoc, 1st district. In the background is E. R. Thayer, assistant secretary.

Information On Civil Defense

(Continued from page 671)

tion is cut down by the shielding, an outside antenna may be necessary.

4. Lighting. A 4-cell hot-shot battery wired to a 150 milliampere flashlight-type bulb will provide low level lighting for at least 10 days. A spare battery will assure light for 2 weeks or more. An electrical outlet in the shelter is recommended, since power may continue to be available in many areas.

STOCKING A SHELTER

Obviously, a 2-week supply of food will be necessary. Foods selected should be easily stored, keep for months without refrigeration, be easily prepared, and require little or no cooking.

Canned foods can be stored for 6 or more months. Food in paper boxes should be stored in metal cans or cabinets. Both should be used periodically, and replaced with fresh items.

Special thought must be given if there is an infant, older person, diabetic, or anyone with special dietary needs in the family.

Recommended quantities and types of food are listed in the pamphlet "Individual and Family Preparedness" available from your city or county CD director.

Minimum water requirement for drinking and food preparation is one-half gallon per person per day.

Water can be stored in advance in clean containers and additional supplies may be obtained from hot water tanks, toilet tanks, and refrigerator ice.

Before entering the shelter, a person should turn off the valve where the water supply enters the house and then open the highest tap in the house. The first prevents the supply of water in the house from draining back into the main; the second allows it to drain to the lowest outlet in the house where it can be used during the shelter period.

Water purification tablets should be included in the emergency supplies.

Heat for warmth and cooking is another important consideration. A major point to remember is that open flames use up oxygen in your shelter area, so methods which have either a low flame or no open flame are the best.

Instructions on recommended cooking and eating utensils, clothing and bedding are contained in the booklet "Individual and Family Preparedness."

In time of emergency, it can be assumed that trained medical personnel will be in great demand; also movement from one location to another may be restricted.

For this reason, the Medical Self-Help Training Program is being originated. Also, special medicinal supplies should be stocked for diabetics, heart patients, and others with special requirements.

The pamphlet "First Aid," available through the CD organization lists the materials recommended for a fallout shelter.

LIVING IN A SHELTER

A major problem in preparing to spend two weeks in a shelter involves sanitation and disposal of wastes.

Temporary toilet provisions will be necessary. Almost any covered container will serve. For disposal of wastes, a large garbage can with a tight fitting lid can be used until it is safe to leave the shelter.

Covered cans are suitable for garbage disposal. Garbage should be drained dry and wrapped in several thicknesses of newspaper and placed in the container.

Quarternary ammonium compounds, available under various brand names at farm stores or dairy supply houses, are especially useful as a disinfectant and to cut odors from the garbage and human wastes. Chlorinated lime could also be used.

Countless other considerations, such as implements which should be stocked, materials for entertainment, and organization of the family to move quickly into the shelter are contained in the CD manuals listed elsewhere in this issue. They would prove valuable additions to waiting room literature.

News Briefs

OVEREMPHASIS ON RESEARCH?

The amount of money the government is giving to support the research programs of medical schools is affecting teaching and other functions of the schools adversely, John M. Russell said in the annual report of the John and Mary R. Markle Foundation, an organization whose major function is support of medical education.

Russell went on to say that, in his opinion, with government grants earmarked so heavily for research, the other functions of training, education and service are not being viewed in the proper balance.

CIVIL DEFENSE FILMS

The American Medical Association has recently distributed a new directory of films available on the subject of disaster medical care.

The films are available on rental, loan, or purchase from various organizations.

Physicians participating in programs who wish to obtain films on Civil Defense subjects are invited to contact the State Medical Society for assistance in procuring the films.

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VOLUME LX

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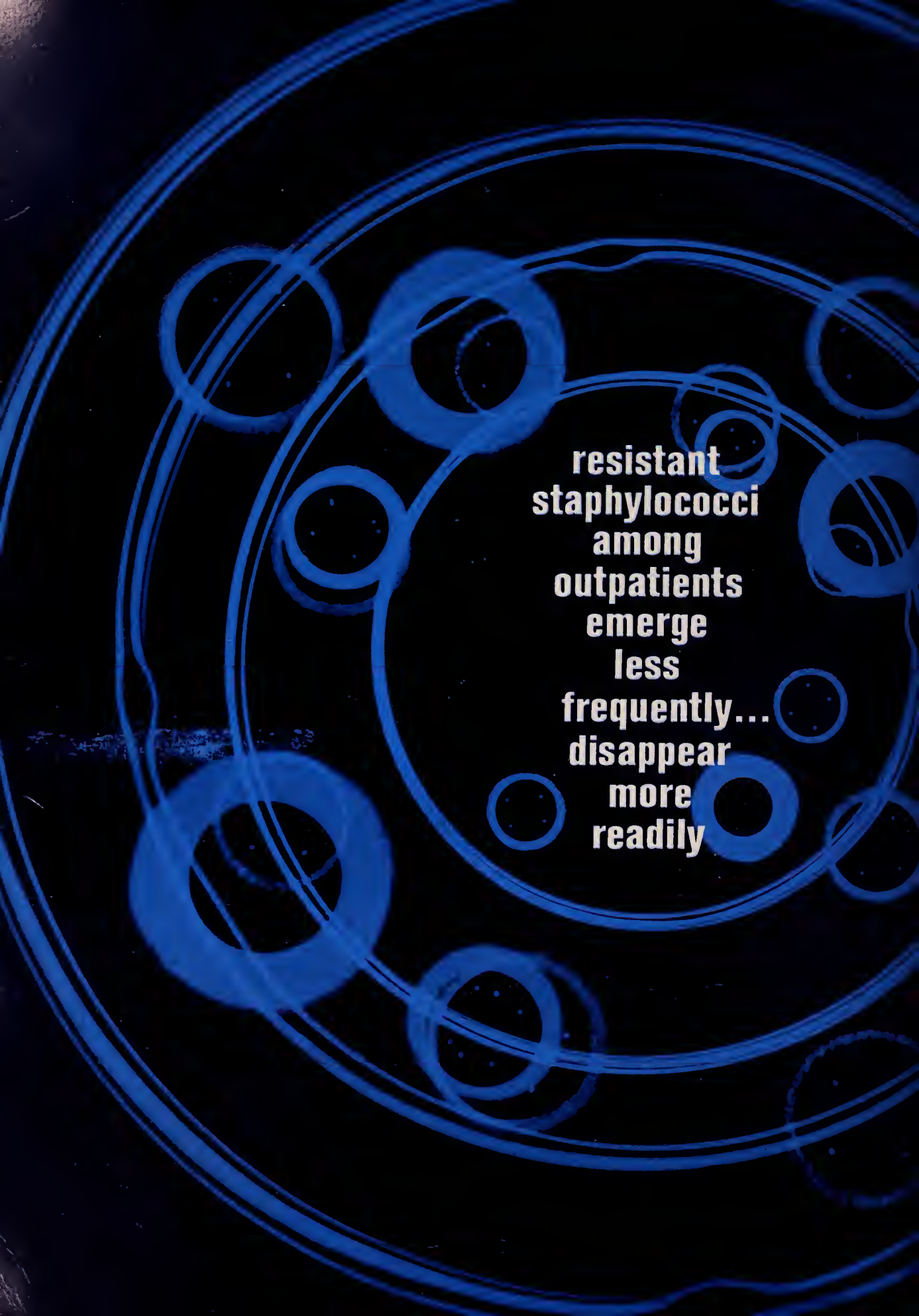
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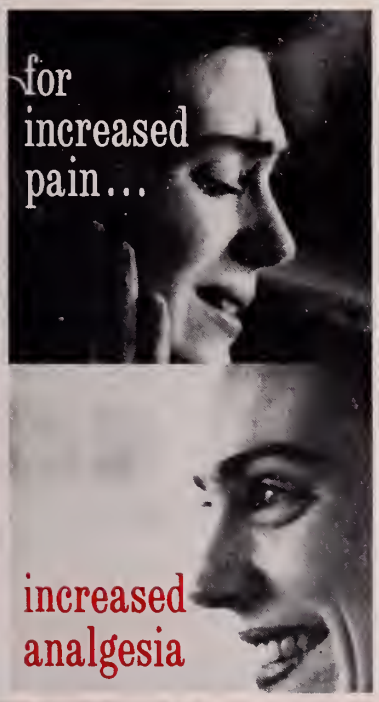

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References: (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

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Bibliography: (1) Jacobs, L.: GP *21*:93 (Jan.) 1960. (2) Shulman, L.: J.A.M.A. *175*:118-123 (Jan 14) 1961. (3) Moore, C. V., in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, ed. 2, Philadelphia, Lea & Febiger, 1960, p. 213.

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